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SECURITY IN THE LARGE FAMILY

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THE concept of security has been much discussed and emphasized in our recent literature, particularly in that dealing with the life and development of the individual. Much recent thought has tended to consider security as one of the inherent rights of the individual. Thus, one hears of the child's right to security in his family setting and the adult's right to security in his economic life. A child, in other words, has the right to be wanted and to be loved; the worker has the right to a job and to be guaranteed the minima of existence.[1]

An opposing point of view is that expressed by the famous historian, Arnold J. Toynbee, who insists, on the basis of his lifelong studies of history, that insecurity is one of the normal conditions of human life. "But for short periods of abnormal conditions of relative security for small groups of people within limited geographic areas, this life of insecurity has been the normal human lot as far back in history as our records go." Economic and political security weaken our capacity and drive for action, and especially for creative action.[2]

In spite of the emphasis upon security in the emotional and economic areas of contemporary living, there is a definite dearth of empirical studies in both fields. A limited contribu-

[1] For a criticism of this tendency, see *Social Problems and Scientism*, by A. N. Hobbs. Harrisburg: The Stackpole Company, 1953. Chap. V.

[2] Arnold J. Toynbee, in a commencement address at Bryn Mawr College, June 3, 1953. For a more complete development of this point of view, see the abridgement of his large work by D. C. Somervell, *A Study of History*. New York: Oxford University Press, 1947.

tion to our factual material, with suggestive leads for further thought, comes as a part of an analysis of the large-family system, based on an original study of 100 large families, made under the auspices of the William T. Carter Foundation at the University of Pennslyvania. Each of these families had six or more living children. A total of 879 children, reared in these large families, were included in the study.

Information on the life of these families was obtained from persons reared in them. The methods utilized in the gathering of the information included directed questionnaires, nondirective interviews, and written family-life-history documents. In 60 of the families, both parents were native-born whites of native-born white parentage; in another 17 families, they were native-born whites of foreign or mixed parentage; in 10, both parents were foreign born; 8 were Negro; and in 5 families, the father was foreign born and the mother was native born. By religious preference, 26 families were Roman Catholic; 8 were Jewish; 3 were mixed Catholic and Protestant; and the remainder were Protestant. By type of community, most of the families were reared in small-town, village, or farm communities. Twenty-four, however, were reared in either New York, Philadelphia, or Brooklyn.

One of the aspects of family life that was explored concerned the feelings of emotional and economic security that were developed by the siblings, presumably as a result of their family rearing. It is a part of this phase of the study that is here presented.

One of the specific questions utilized in the study was: "Do you think a large family makes for a sense of security among its members: (a) economic security; (b) emotional security?" Informants were encouraged to write out their thoughts on this, and the question was discussed with those who were interviewed personally. Relatively adequate responses were obtained from 90 sibling informants in as many different families.

What do 90 large-family siblings say about large-family living and feelings of security? Their answer is overwhelming. Seventy-three of the 90 agree that large-family living produces feelings of security; 17 appear to disagree. The ratio is more than four to one—81.1 per cent to 18.9 per cent.

Is one kind of security emphasized more than the other? The answer is decisively yes. Only 4 informants stressed economic security alone. Another 43 mentioned both economic and emotional security, but in most instances emphasized the emotional aspect as the more apparent and important. The remaining 26 spoke or wrote only of emotional security.

These informants, then, clearly presented a majority-feeling that emotional security is not necessarily related to economic security; that the former is of greater importance; and that there is something in the atmosphere of the large family that tends to promote emotional security even in the face of economic, and other, difficulties. Their specific attitudes as to the relation between large family living and security feelings can be summarized as follows:

I. Attitudes Toward Emotional Security.—Sixty-nine of the informants felt that the large family provided emotional security for them, and some of them gave more than one reason as to why this was so.

Eighteen felt, with Dr. Toynbee, that the challenge of a difficult situation created a positive stimulus; or, as one informant put it: "In a large family a child learns early that life is a difficult proposition and that many occasions arise when negative action only makes things worse. A positive viewpoint is developed." According to others, this "positive viewpoint" was that, in a group in which material things have to be spread thin, and in which personal relationships are intricate and involved, an appreciation of the value of the dependable and coöperative person is developed. Since all of them share the exigencies of the group, the member who contributes, either in work or in warmth of relationship, adds to the wealth of the whole group. The informants felt that since there was this special need in the large family, the members usually tended to grow in that direction. Thus, it was the numbers of dependable and loyal people that spelled security for every member. Some of the informants remarked:

> "We did feel a sense of security that must be lacking in small families, because we were required to work together and to the well-being of all of us. This feeling remains—even in our adult years."

> "We have the philosophy that if we stick together, we can get through any crisis. If we stand alone, it makes a hardship on the family. . . .

> Fear with us was unknown, probably because we never stood completely alone."

> "Emotionally there was strength in being a member of a large family. A crisis was met by every one and to back up an individual there was a whole clan."

Another 26 of the informants felt that mere numbers of family members created a sense of security, no matter what were their individual personalities. There were, however, two different attitudes about the relationship between numbers and security. The first was voiced by those who found emotional comfort in identifying intimately with a large number of people. There were always "lots of your own around." Illustrations of such feelings usually concerned some sort of contact with the outside world, some fright or problem from which you could come back "home" to the family, or which some members helped to ease for you. Second, there were 18 cases who explained that the strength of numbers lay in the fact that, although you might not be able to get along well with the whole group, there was always sure to be some one with whom you could pair up and find adequate help and companionship. As one writer put it:

> "We always had at least one other family member to play with. In smaller families, if you are feuding with your only brother or sister, you would be quite lonely. One very seldom feuds with seven or eight other people though, so in a large family there is always some one left to turn to for consolation and love."

There were 37 informants who very clearly indicated that their sense of emotional security had derived not just from mere numbers of family members, but from the number of siblings with whom they had lived. This comprised slightly more than half of the cases who reported positively on emotional security, and was the most common response. In view of current psychiatric and child-development literature on the subjects of security and of sibling relationships, this material was thought-provoking—and for four reasons:

First, a child's security has been considered almost exclusively as based on the adequacy of the parent-child (and usually just mother-child) relationship, while the rôle of siblings has been considered chiefly in the light of "displacement" and "rivalry." It is rarely that one finds any but the

negative aspects of sibling relationships, and warnings as to how to deal with them.[1]

Second, although the number of close-kin relationships has been dealt with by anthropologists who stress the security value of the consanguine family, discussions have been largely in terms of adult protectors and providers. James Plant, as psychiatrist, went a bit farther than this in describing the effects of number of family members. In his clinical experience, "extra members," such as aunts, uncles, and grandparents, provide more sources of security or insecurity, but arouse such feelings only in relation to certain people in certain situations and not as a generalized personality trait. Dr. Plant felt that "there are few more exciting trends than those in the numbers of relatives living in the household. Apparently the decrease in the family is rapidly intensifying the emotional load on a very few people. The issues are clearer, the successes richer, the failures not to be escaped from."[2] He suggested that "all trends as to the number of persons in the household should be broken down into the relationships of these persons to the child."[3] Sibling relationships, however, he did not discuss.

Third, the significance of the peer group in providing a sense of security is well recognized; but having come into prominence in an era of the small-family system, the peer group has meant, exclusively, non-family peers. Children are said to find security in the situation of being age-culture mates in an adult-dominated world. They discover that they are crew members in the same problem-ridden vessel. Apparently, from our case records, siblings from large families found such crew members among peers within the family group. A possibly significant comparison between the small family and the large family in this respect may be pointed up by the remark of a woman with only one sibling:

> "Not until long after we were both married did my sister and I discover that we had had the same kinds of problems with our parents.

[1] For the positive aspects of sibling relationships, see *The Sociology of Child Development*, by James H. S. Bossard. New York: Harper and Brothers, 1948. Chap. V.

[2] See *The Envelope*, by James S. Plant. New York: The Commonwealth Fund, 1950. Chap. I and pp. 16–17.

[3] *Ibid.*

> Each one of us had thought our own troubles were unique and that the other one had a better relationship. Our parents had made their own neurotic demands upon both of us, but had managed to keep us far enough apart so that we did not know we were sharing the results similarly."

In the large family the weight of the numbers of children makes it difficult for parents to keep children so apart. In the cases under consideration, there was only one that reported such a situation, describing a mother as "managing to keep all the children at variance with each other." The child-group numerical superiority seemed so significant in all other cases that they were analyzed individually.

Fourth, though the rôle of the peer group has been appreciated, the differences in social situations obtaining as between a non-family and a family peer group have not been so appreciated. Edith Buxbaum has written:

> "Whereas the young child finds in the group support for his new-found physical independence from mother, the adolescent finds reassurance for his moral independence from home. Both child and adolescent feel deserted, ousted from the protective atmosphere upon which they have used to rely and not yet sure enough to face the world alone. The group is a highly welcome shelter in the meantime."[1]

In the large family, the physical dependence on the mother is rarely so great as in the small family. Even feeding, weaning, toilet and cleanliness training are matters that early become the responsibility of other siblings. The atmosphere may not be so protective in terms of a one-to-one personal relationship; but neither is the child "ousted" and "deserted" so suddenly from his more generalized protection.

Five distinct contributions of numbers of siblings to emotional security were noted.

1. Siblings turned to each other when they did not get enough attention or understanding from a harried or indifferent parent. When a parent was cruel or thoughtless, the children stuck together to protect one another. One informant mentioned, for instance, the horrors of having an alcholic father, but said that the children had presented a solid front against him. Another wrote:

[1] See "Transference and Group Formation in Children and Adolescents," by Edith Buxbaum, in *The Psychoanalytic Study of the Child*, Vol. I. New York: International Universities Press, 1945. P. 363.

"We children at times felt that we had been wronged by the adults—so got together, talked it over, and if we decided that we had a good case, we would take it to our parents."

Another, fully aware of the "rivalry" aspects of sibling relationships, said:

"What can be lost in this area from competition to get parents' attention is gained from the fact that children find their security in one another."

As this article was being prepared, one of the authors tuned in on a radio discussion of teen-age voting. The representative from Georgia, the only state that has teen-age voting at the present time, described Georgia's experience. Teen-agers vote along family lines, and along sex lines within the family. The girls vote with their mothers; the boys, with their fathers. However, when the family is so large as to contain six children, this does not hold. Apparently the children talk among themselves, make their decisions together, and even influence their parents' votes.

2. Other informants felt that their own siblings had a better understanding of the problems and new situations that younger children faced than did their parents—because the siblings were still children together. They realized how frequently, and under what circumstances, youngsters do feel insecure, and the older siblings did something about it. What was done, specifically, in some families was reported:

"My oldest brother took my youngest brother to his first Scout meeting. I took him to his first day at school. When a child is faced with a new experience it must be a great comfort to know that someone is there who has been through it all before."

"Mother spanked my third brother. Sister cried as hard as if she had been spanked and as soon as Mother left the room, she ran to his side, put her arm around him, and said through her tears, 'You'll be all right, don't cry.' "

"Three of us had mumps at the same time. We could console one another as we lay sick in bed."

"The boys down the street and my second brother would get into a fight. The minute my eldest brother and I discovered it we were also in it, beating the other kid up or helping our little brother to hold his own. Surely it is a good feeling for a child to know there are others to help fight his battles, whether he be right or wrong."

There may very well be a great difference in security feeling, depending upon whether it is siblings who help a child

to fight or encourage him; whether it is Mother who rushes out to protect or chide him; or whether he has to fight it out all alone.

3. Three of the informants thought that security feelings were related to the adequacy of an individual's performance and the range of his skills. They felt that siblings were better teachers than parents. John Honigman recently substantiated our informants when he wrote:

> "Sometimes, siblings, whether playmates or responsible nurses, constitute a source for the derivation of future behavior patterns in relation to peers. Often being closer to the learner in age and experience, peers reduce the great age gap existing with respect to parents."[1]

Although security and adequacy have been rather strictly separated in psychiatric literature,[2] and there is some logic in the separation, there is also some logic in the reports of our informants. Siblings, they said, were able to understand how hard it is to learn something new; they had so recently been through such learning processes. They were, therefore, patient, and got right down to their students' level. They did not push, and so frighten and frustrate, as adults frequently do. Siblings had no vested interests in teaching younger siblings that would result in unrealistic expectation. They shared skills for the fun and companionship of it. Also, with many children in the family, there were many and varied skills to teach one another. One informant listed all the skills of the children in a family of seven. She was fourth in order of birth. The first four had all had different skills. Each had taught the others a bit about his own personal interests, and they had passed all of these down to the siblings who had arrived later.

Another aspect of the adequacy of performance was related to the fact that in a large family there are usually a few siblings who are going through a certain age period in close succession. They not only share the age period, but some of them are just slightly ahead of the others, with a little bit more experience. As one informant explained: "We could talk over adolescent problems—dating, dancing, necking,

[1] See *Culture and Personality*, by John J. Honigman. New York: Harper and Brothers, 1954. P. 302.

[2] Plant, *op. cit.*, pp. 18–19.

drinking, smoking." The inference was that this gave them more security in knowing how to perform than they would have found in talking these things over with a "passé" generation.

4. In one case it was stated that emotional security came from numbers of siblings because there was little opportunity for the emotional coddling of any except the youngest. The writer compared the small-family system unfavorably in this respect.

5. Finally, two cases spoke of the large family as giving security within the group, but suggested overdependency upon it for emotional satisfaction to such an extent as meant a lack of security away from it. One of them wrote, somewhat confusedly:

> "The feeling of security I have at home, which means wherever the family is, is something I cannot find away from them. But I am secure away from them in that I know they will always be there if I turn back. I can depend on all my brothers and sisters, and both my parents, even if the rest of the whole world rejected me. A tremendous interdependence, even if we don't all live together any more. . . . We have lived much and through much together."

It might be asked whether, were adults from small families asked the same question, their answers might not produce the same percentages. This is quite possible. The significance of the above responses, however, seems to lie not in the proportion of security and insecurity feelings, but in the believed sources of those feelings, and the reasons for them. They seem to be strikingly different from the material on, and comments from, members of the small-family system. From sheer curiosity, the authors recently read through 30 family case histories collected at the William T. Carter Foundation and written by college students with two or three siblings. Sixteen of these discussed their feelings of emotional security or insecurity. Fourteen of the 16 explained these feelings in terms of their relationships with their mother or father or both. The other two related such feelings to peer groups outside the home. There is no reason to believe that the respondents from small families had been more influenced than those from large families by current pronouncements on causes of security. Yet the explanations given by the two groups were quite different.

Twenty-one of the informants were just as decided in their views that the large family did not create a sense of emotional security. With the exception of one case, all those who analyzed the reasons for this described them in terms of the struggle for life's having been too much. Whereas, for other families, this struggle had been a stimulating challenge, in these it was said to have been sufficiently weighty to tip the scales in the direction of insecurity. Dr. Toynbee has cited a few cases in history where challenges were too severe to provoke a positive response. There were some large families in this study whose informants felt this to be true of their own families. A sibling from one of them wrote:

> "In the church I learned what it meant to be needed and experienced deep satisfaction when I received thanks for a task well done. It seemed there was never time for any such expression in our house. Food, a clean house, and clean clothes always seemed of prime importance. . . . The numbers of children in the family decide the volume of work that must be done to meet their needs, and when one becomes so busy providing food, clothing, and shelter that there is no time to really live, a large family is a disadvantage. We did have happy times together, but there were so many gaps that were not filled we could not appreciate these joyful days fully."

In another case, an alcoholic father was abusive and cruel and "for some reason or other, we never developed much of a tradition of mutual aid among each other." Again, a mother and father separated and "family inconvenience, intensity of family struggle for financial support, and unfair emotional upheaval were the consequences of such a marital disaster." One more informant felt that his insecurity resulted from his being the last child in a family with six older girls. He explained that he had got no support from his sisters of the kind a person usually gets from siblings. What seems significant in the examination of all these 21 cases is that it was not just the severity of the family problem that created insecurity, but that its nature had prevented the family from using the best resource—the unity of numbers. Parental relationships had been inadequate, and children had not been able to compensate for this by forming close sibling ties.

II. Attitudes Toward Economic Security.—Forty-seven of the informants felt that the large family developed a sense of economic security in its members, while 43 did not. Three

informants, explained that money and material things had been abundant, and that they had felt secure economically. The other 87 made it clear that large-family living had meant a continuous consciousness of the pressure of many needs. The responses on economic security and insecurity, therefore, came almost wholly out of situations of acute economic awareness.

The major difference between those who felt economically secure and those who did not seemed to lie in whether or not the whole family worked as a team. When they did, the informants stated with positiveness that a large family makes much more for economic security than does a small family. "Each individual is more aware of economic problems and contributes more himself." "We all worked together and could always depend on each other if we needed something." In many of these cases a sort of family mutual-aid society was existing to the present time, when siblings were grown and separated. A typical example was this:

> "My eldest brother wanted to get married. He could not find an apartment, but he could buy a trailer. My folks agreed to let him put it in their back yard. My brothers agreed to help fix up the inside. However, he lacked about $1,000 toward the purchase price. . . . If he could not get the money he could not get married because they had no place to live. He . . . asked me to lend him the money and I answered, 'Yes.' It never occurred to me not to grant his request. Another example, the second brother married, moved to Florida, had two children and, with his wife six months pregnant, lost his job. My father by good fortune found him a job in his line. He wrote giving all the necessary details, beseeching him to come, and assuring him that the family was back of him financially. He agreed to come, and the family members contributed each as he could towards moving the family north."

In contrast were those families without such *espirit de corps* whose sibling informants had felt economically insecure. They spoke of lack of funds' creating competition among the members of the family; of older children's having always resented the "sacrifices" they had to make for the younger ones; of children's not being able to work in proportion to the work they make; and, "when size makes the struggle for life paramount, the responsibilities are too much."

A second difference between the two groups of informants lay in the extent to which their families stressed non-material values and found satisfactions in them. In families where

highest values were non-material ones, the informants again felt that a large family is much more conducive to economic security than is a small one, for the simple reason that in a large family one learns early that the best things in life are free. They wrote:

> "If parents 'think poor,' then the children will be discontented about their lot and worried about the future."

> "I think that a large family could make for the maximum of economic security, with skillful handling on the part of the parents. With very little money, it is possible to live a kind of life which, while frugal, is not niggardly and is rich in imagination and things of the spirit."

One informant expressed great satisfaction over not having been able to spend money frivolously for family entertainment, because they had, together, discovered the wealth of free "cultural opportunities" that the community provided.

In the material on economic security and insecurity, the rôle of the parent assumed much greater significance than it had in connection with emotional security. Parents were applauded for instilling "higher values"; for being good managers; for fostering sibling coöperation without exploiting any of the siblings. Or they were accused of being the reason for the economic insecurity of the whole family, since they had none of these virtues. It is interesting to note that the informants in these particular large families expressed a greater need of economic leadership than of emotional leadership from parents.

Finally, four cases felt that the large family produced economic security and emotional insecurity. They were among the informants who had come to believe that life is an individual battle. One had to "stand on one's own feet and depend upon no one," and "make one's own way." The four had been successful in so doing, quite early, and now felt economically secure in themselves. They expressed resentment against any siblings who happened to ask them for help and a great reluctance to, and humiliation about, having ever to ask for help for themselves.

III. Insecurity in the Large Family.—Although 17 of the informants felt that the large family resulted in both emotional and economic insecurity, they were very cryptic as to why this should be so. An examination of such case materials as they gave showed no significant differences be-

tween their families and others so far as stated emotional and economic problems were concerned. Certain "possibly influencing factors" in these cases were then examined. These were: sex of informant; size of family; birth order of informant; area in which family lived; religion; and occupation of father. Statistical analysis of the 90 cases were intended only as a search for pertinent questions, and some questions did arise:

1. Are economic and emotional insecurity more closely related in the male than in the female? Is the male more oriented to the responsibilities of providing, economically; and does insufficiency in this area of his early family life disturb his emotional security more than it does his sister's? Or does a large-family group offer greater emotional satisfactions for a girl, even in the face of economic hardship? Our study shows that although almost the same proportion of male and of female informants felt economically secure, the males showed a lower percentage of emotional security and a higher proportion of negative responses toward both emotional and economic security.

2. Is the degree of largeness of a family related to security feelings in its members? If there is security in numbers in a primary group, as our informants suggest, is there more security in larger numbers? In order to inspect this, with a reasonable number of cases, the families were divided into two groups by the median size of family in the sample reporting. Exactly half the cases had seven or fewer children; the other half, eight or more. The comparison here shows quite clearly that more of the families with eight or more members reported feelings of both emotional and economic security.

In an attempt to discover whether there was some point in family size that produced diminishing returns in security, a tabulation was made of individual family sizes. This, of course, made samples of very small numbers. Nevertheless, there was an increasing percentage of security responses with increasing family size, and a diminishing percentage of negative responses toward security. The one difference that appeared was that economic security was highest in the six-member families, and lowest in those with fourteen, fifteen, and sixteen members.

3. Does one position in birth order cause more insecurity than another? Our older children show the lowest rates of insecurity. Although both older and younger children, as informants, had pointed to the preferability of a middle position in the family, the middle siblings expressed more economic insecurity than any of the others and more emotional insecurity than did their elders. Yet these elders were the siblings characterized as the "exploited." Though their security records were more positive in all respects, they were the ones who had most frequently been through the repeated experience of displacement through subsequent births, and who had served most time with the vulnerabilities of the large family—the economic ups and downs, the illnesses, deaths, separations, and increasing complexities of relationship. Did they feel secure through these experiences because they had been the first members of a (then) small family? Had they, in their earliest years, got the benefits of undivided attention and economic resources so that the pattern of security was indelibly printed upon them?

An inspection of their case records makes this seem hardly likely. Some of these "elder children" (according to definition) were in families so large that being an older child meant being a third or fourth one in a family in which siblings had come close together before the informant's birth and after it. With these, there had been a high degree of emotional and economic sharing from the moment they entered the family. There had also been a high degree of emotional and economic responsibility. Was it the latter, then, that created a sense of security—in being able, and in being able to provide for one's dependents? Those younger children, who were so frequently designated as "pampered" by their siblings, expressed themselves as feeling the least emotionally secure, although they felt more economically secure than the middle siblings. These younger children had the advantage of economic help from elder and middle siblings, but they did not express feelings of economic security in as high a percentage as did the older siblings.

4. Does the area of residence of the large family influence the security feelings of its members? Do some areas provide opportunities for maximum economic support of a large group? Do some areas have subjective values about family

size that penetrate into the large family's attitudes about itself? Many of the informants stated their convictions that cities and suburbs were not the healthiest locales for rearing a large family and that "the country" was its natural habitat. Feelings of emotional security were markedly more prevalent among the informants reared on farms, in villages, and in small towns. In regard to feelings of economic security, the differences were slight, but also in favor of the farm and small-town families.

5. A number of the informants mentioned their religion as being more closely related to their security feelings than was the size of their family. This raised the question: Given a large family, does its religion influence the security feelings of children? Unfortunately, the cases of Jewish families and of families with mixed religious parentage were too few to tabulate even in this limited study. The bulk of the cases were Protestant and Catholic. Our material shows a higher percentage of security in Catholic families. Again, this may have to do with intra-family values, and with community attitudes on family size in relation to children's security.

6. Occupation of the father, in terms both of status and of income, seemed an important factor to analyze in relation to security. Occupations, in this sample, were so diversified as to provide very small numbers of cases. Only the four largest were tabulated. These were proprietors and managers, farmers, skilled workers, and professionals.

Children of a professional parent fared least well in terms of security. These informants were children at a time when the birth rate of college graduates was not only the lowest of all educational groups, but had not yet started the increase that has occurred since the 1940 Census. Was the large family, then, unpopular and unwanted in the professional class, and did this reflect upon the security of the children? Were professional standards of living at a professional-income level a great strain upon a large family? The children of farmers had high emotional security, the lowest economic security, and low negative responses. Does this add to the evidence on the divorcement of large-family security from economic hardships and add to that on the importance of the intra- and extra-group relationships? What is it about the large families of proprietors and managers that makes

them experience the highest rate of security? Are these the people who, in an earlier era, were economic individualists, who made their own way and welcomed children to further it? And were the children of skilled workmen, who struck a consistent pattern of medium security, in a position of having much financial confidence and comparatively little value-judgment against family size?

Finally, the suggestions of several informants that the spacing of the children was related to insecurity led to an investigation of the cases in which this material was available. Two interesting situations came to light. First, insecurity was felt in families where children were greatly separated in age and could find no playmate, but only "overseers" and "little nuisances." Second, it was felt in cases where one or two children were members of a small family for many years and then became increasingly depended upon by parents who had produced large families fairly late in life.

To summarize, the foregoing materials suggest that there are group factors that influence the security feelings of children, over and above the more generally recognized individual parent-child relationships. The materials suggest, further, that a large family is a distinctive kind of group and that to study security in the small-family system is not necessarily to understand it in a large family. Specifically, the following very tentative hypotheses are offered:

1. The large-family system, because of its numbers, creates its own peculiar challenge to security, economically and emotionally. It also offers certain unique resources. The adjustment between the two seems to be related to the security feelings in the members of these families.

2. Within the separate large families, there are individualized factors, such as number, sex, birth order, and spacing of children, which seem important in terms of security. The exact significance of them, however, relates only to the large-family situation. Sex, birth order, and spacing of children may have quite different meanings in the small family.

3. The position of the large family in respect to other societal groups seems to have some effect upon feelings of security, particularly as concerns the values, and the attitudes toward family size, of the neighborhood, religious, and occupational groups.

THE RESPONSIBILITIES AND DUTIES OF THE WARD PHYSICIAN*

SAMUEL W. HAMILTON, M.D.

THE ward physician in one of our mental hospitals has usually had a long schooling—grammar school, high school, college, medical school—and after all that he has had an internship of a year or more. Perhaps for some reason he has come to us without the internship, which he will undergo later, but in this general consideration, we assume that the internship is behind him. He is, therefore, equipped to take care of sick people, and to take care of them very well. Perhaps he has come to us because, in accord with the spirit of the times, he intends to be a specialist and we offer good training in the specialty that he prefers. Perhaps he comes to us because he is broke and needs to accumulate some capital. This probably happens seldom in these days; the medical course is so costly that, they say, only sons of very well-to-do families go through it. Another possibility is that he wants to get married and we can offer him a large room with bath, which general hospitals cannot do.

Probably the doctor's service accommodates 200 to 800 patients. My first service had only 115 beds, but it was a lively one. I suppose a society composed of men from New York state hospitals and a veterans' hospital wonders if my tongue did not slip when I spoke of a service with 800 beds. It did not. You will recall that I have been on the road a good deal, and have seen public mental hospitals in many states. Indeed, on Wards Island forty-five years ago, we had a service of a thousand beds; to it were assigned two physicians, if the second one could be spared.

This may be a pathetic situation—several hundred human beings dependent on one busy man, not only for help with their emotional problems, but even from day to day for their creature comforts. They may be crowded, one may annoy

* Presented at a meeting of the Long Island Psychiatric Society held at the Veterans Administration Hospital in Northport, Long Island, May 15, 1951. This was Dr. Hamilton's last public address.

several, and questions of food, of clothing, even of ventilation, may never be settled save when the doctor has time to settle them. We will drop the matter of crowding, for there is no such condition in veterans' hospitals; but the patients that the veterans' hospitals cannot take for the next eight months add to the crowding in the state hospitals.

It is of primary importance that the ward physician know all his patients. In the veterans' hospitals they do, except sometimes when a shift of service has just occurred and the doctor has not yet got acquainted. In many state hospitals there are many patients who are not really known to any physician, except in the social-service sense that there is a record of every one in the proper file. This may not be important where the ward personnel is strong and stable, for a strong charge nurse—like the first one in my experience, who taught me many things about what patients do and think and are—will keep the physician well posted on what needs his attention. Unfortunately the hospitals that are short of physicians are usually short of strong charge nurses, and the person who looks after the ward may be a well-meaning, half-trained man or woman who perceives but little and has meager verbal facility with which to convey to others what he does perceive. I repeat that the first responsibility of the ward physician is to know all his patients.

All sorts of things happen to us human beings. Bones break, scalps get lacerated, lungs and livers, gall bladders and appendices go wrong. Then, too, our patients have minor ailments that must be differentiated from the more serious ones. In some hospitals, any one who is sick is turned over to a clinic that specializes in physical diagnosis, and that seems like a good plan, since it leaves the ward physician freer for other things. In many hospitals in this land, unless the ward physician takes time for physical diagnosis, the patient gets little attention, and treatment—except for conditions that demand surgical operation and huge infections, like pneumonia —is given by the ward physician or nobody. So the second responsibility of the ward physician is to look after his patients' aches and pains, or see that some one else is properly notified and looks after them.

The third responsibility might seem at first sight to belong first on the list: to study the state of mind of each patient

with a view to alleviating his illness. I did not put it first because until all the patients on a service have at least been checked against their case histories, it seems a bit unfair for the physician to be spending hours with a little handful of them. When he has made a careful survey of his service, he will of course plan matters so as to spend more time with some, less with others. I did not put this responsibility second because in so many hospitals it has been already pushed back, and also because I find that the therapists whose work I most trust seem to think that they cannot properly turn a deaf ear to the somatic complaints of the patients to whom they are administering psychotherapy.

The ward physician should have considerable help with his studies during his first few months on duty. Primarily this help has to do with making the study searching and its results illuminating. Secondarily the physician should be helped to make his notes pungent. The amount of feeble, repetitious, ill-phrased, and obscure material in the mental-hospital records of this country is appalling. Even bad grammar is not unknown. The senior should help the junior to grasp what is not always understood: The record I make is primarily for my own use, to be sure, so that I can easily follow the patient's course, but after that it is for the benefit of my colleagues, not only this year, but for years to come, and not only for other young assistants, but for anybody up the scale to the director (manager, in the V. A.) and the chief medical inspector. When the ward physician is convinced of that principle, he will try to make literature of his notes, not mere changes of the moon.

So our ward physician will explore the mental state of all his patients—the responsive, the dull, the antagonistic, the ones he likes and the ones he does not care for personally. Perhaps he cannot carry all this information in his mind, but a glance at the clinical record of any patient will bring a vivid memory of how he looks, how he acts, how he talks, and the important features of his mental content. To repeat, the third responsibility is to study every patient's state of mind.

The fourth responsibility of this hypothetical ward physician whom we are considering is to apply proper treatment to his patients. This topic covers a considerable range.

A. He already knows before he comes to our mental hospital

that he must maintain a cheerful and encouraging air. A few physicians go further and are hilarious on many occasions. A respected and beloved friend of mine in past years was of this type. He laughed and joked with his patients repeatedly. I have heard a lady comment somewhat ruefully that she had wanted to complain about something, but Dr. Jones made so much fun in the ward that she did not get a chance. He knew quite well what was going on and took this method to avoid discussing a topic he considered trivial and not worth debate. Most of us do well to let our countenances carry an expression ranging from impassivity to quite good cheer. Whether it be treatment or not, let us assume that our assistant does not look gloomy or hostile.

B. An elementary type of treatment—not always easy to carry through—is to get the patient to disclose what is troubling him. Of course he can make a complaint, probably with little effort, but we know that the complaint may represent only one layer of several that encompass his fears, frustrations, antagonisms. The ward physician, soon after he first went to work in our mental hospital and perhaps even back in medical-school days, was shown how to become a skillful listener, quietly encouraging the patient to go on and on with his story and its associations till the old roots are uncovered. Sometimes amazing results will reward him; sometimes hours of work will merely uncover a layer that better be covered up again. Incidentally, the association test used to be a fruitful means of finding doors into the unconscious, and the ward physician will of course know how to use it even if he prefers less laborious methods. Amytal and pentothal injections are much simpler, and our doctor will handle them adroitly.

C. The most elaborate and best organized technique for digging below the surface undoubtedly is psychoanalysis. This raises the question whether our ward physician should go to the trouble and expense of being analyzed, so that he in turn may analyze others. If he thinks he should, I would try to arrange his hours of duty so that he could go through the tedious process of analysis with as little hardship as possible. And when he was done with it, I would do whatever might be possible to utilize that special experience so as to throw more light on patients in all parts of the hospital.

But the number of hospital patients who are suitable for a full-scale analysis is relatively small, and so most of our ward physicians do not need that special skill for hospital work. From the standpoint of the administrator, it may be remarked that he does not wish to have many ward physicians getting analyzed at the same time because he knows full well that they will drift out and take up private practice; psychoanalysis is extraordinarily popular in these United States, and its practice is lucrative. To quote Dr. Overholser: "At the moment there is a tremendous vogue of private practice and most of the younger men entering psychiatry look forward to the day when they may enter practice and, hopefully, become wealthy."[1] So one ward physician under analysis at a time is preferred procedure.

D. Hypnotism is a method of exploration and also an instrument of treatment. It has always been looked on with suspicion by the medical profession in this country, perhaps because it is used for entertainment and other minor purposes. I think we do wrong in not training our ward physicians in its use. Perhaps one or another of them will be frivolous about it, but mostly they are just as serious physicians as we oldsters. Opportunity to work with this method under a master should be afforded as freely as opportunity to learn insulin therapy. Not many of our patients will respond in a fruitful way, but a few can be made much more comfortable.

E. In the matter of physiotherapy, our ward physician cannot be expected to give massage or stimulative hydrotherapy or electrotherapy, but if he has at some time actually handled the apparatus of these treatments, he may be able to give better instructions to the technician who is treating his patient. A demonstration by the doctor may be a surprise, and more valuable than considerable talk. I believe that all such procedures should be included in our training and, therefore, among the responsibilities of the ward physician.

F. Psychodrama is a subject that most of us know too little about. It is a quite special form of treatment, and is strong medicine, they say, stimulating repressed patients to bring their conflicts into the open. Sometimes it goads a catatonic to dramatize by attacking some one on the stage. Obviously

[1] Annual Report of the Federal Security Agency, St. Elizabeths Hospital, 1950.

it is not available to us unless carried on by skilled personnel, and it is dangerous business unless under medical direction. Our ward physician should be sent somewhere to master the essentials of psychodrama, so that when the hospital undertakes that therapy, he can direct it, if assigned thereto.

G. Occupational therapy is a term of various meanings in different jurisdictions. I use it of the arts and crafts and some heavier physical labors, directed by trained personnel and run with a view to the patient's needs rather than to the operation of the hospital. It tends to degenerate into hospital industry plus making pretty things that will go well in the semi-annual sale. Probably on Long Island you need not guard against such degeneration, but what can be expected in a hospital where the salary is consistently too small to bring in a director or aide with any special schooling? The ward physician should have facility in one craft, so that he can drop into the shop and demonstrate how the weaving or the carving or the hammering should be done.

H. Physical training is sometimes called physical education. It may have both aspects in our hospitals, but above all else it is a therapy. Since one who is himself athletic can better judge the capacity of his patients for strenuous exercise or for mild, if the doctor played shortstop on his college team, so much the better. Perhaps he does not feel quite up to that at present, though he can go on the field when the patients are warming up and bat a couple of well-directed flies, but he should keep up his bowling, or fencing, or pingpong. In some parts of the country he will naturally hunt or fish, because every one does it. Around New York that is optional.

I. Our ward physician will be well versed in the so-called shock therapies. Insulin therapy has been considerably eclipsed in later years, but is still useful to some patients who are not reached by simpler procedures. Our physician will have worked with a master of insulin treatment and will, therefore, be able to substitute on any service on which that measure is employed, or indeed to set it up on his own service. If the latter, he will know what special attention to give that group of patients immediately after the treatment—whether they need an especial show of affection, or stimulus to talk, or a varied program of physical and cultural pursuits.

J. Group therapy is esteemed now for several good reasons. Some men are natural group leaders; others have to be coached. All are impressed with the overwhelming load we face if we try to give everybody enough time to unwrinkle his emotions, and they welcome a procedure in which advanced patients unwittingly help the physician to drive his points home. I have no doubt that group therapy should be more used. Shall we say that our assistant physician should practice it? Possibly, but perhaps the group therapist should be chosen on the ground of special bent rather than because he is a man of all-around accomplishment.

K. Cultural interests have sometimes been neglected by able physicians whose training and thinking have been along purely scientific lines. Music, for instance, has been viewed as merely entertainment. The choral society of the Third Evangelistic Church of Petersonville has offered to give its dress rehearsal at the hospital and the offer has been accepted. On the evening of the recital all the same patients are in the amusement hall that assemble for the movies. Several of them talk throughout the evening; a couple of women pop up now and then and gaze at the far corner where special voices seem to originate. The patients who enjoy interesting music may deprecate such distractions the next day, but they have learned that musical susceptibilities do not count—the only important thing is the number of patients who have been brought out of their wards.

Our ward physician is a bit of a musician. He joins the group and sings an acceptable baritone, and he plays some instrument, be it pipe organ or piccolo. When he gets up the administrative ladder, he will have musical affairs for the musical and movies for those who want them, even though they grumble all the way through. Moreover, he will have studied what a department of music can do for the patients, far beyond mere entertainment. If assigned to give advice or supervision to such a music department, he will be well equipped for the task.

L. No doubt every one of you here has not only a library, but also a librarian. That is not the case everywhere. Our ward physician finds time to read—though I'm sure I don't know when—and will give the librarian every support on his service. Aside from the general reading for relaxation, an

occasional patient will be encouraged to read to a purpose, perhaps fitting himself to see his job in broader scope and preparing himself to do it better.

These twelve points of treatment may not cover all for which our ward physician is responsible, but they cover much. I think they will keep him busy if he has a large service. We include them all in the fourth responsibility.

We are well agreed, I believe, that a mental hospital should be a center of mental-health activities for its district. Among other things, it should maintain outpatient service for its own former patients and also for those in the community who need psychiatric help and cannot get it from local agencies. Ward physicians, after a year or two of intramural experience, should have the opportunity to work in outpatient clinics under supervision at first and later independently.

I am confident that the ward physician we have been envisioning will be able to acquit himself well in a clinic within two years; it is, therefore, his responsibility to do so. But here we run into certain administrative barriers, fortunately not present in all areas. The Veterans Administration insists on having a separate staff and separate authority for its outpatient work. A tendency in that direction can be traced in the New York State service, but it has not become definite. We will call this, therefore, the ward physician's fifth responsibility in case administrative barriers do not forbid.

Public education, so-called, is a sixth responsibility of the ward physician, at first under careful advice and guidance. The young sometimes speak brashly when in a friendly atmosphere, and no atmosphere is more friendly than that of a Parent-Teacher Association when asking what to do about their erring children. The physician should check his facts and conclusions carefully with his ranking officer, but should cultivate easy speech on his feet and his best public manner in address.

The seventh responsibility is research. Research, we are often told, is of prime concern in all medical work. There is so much we do not know that needs desperately to be discovered, preëminently in psychiatry. Some of these clarion calls would take us all off our present jobs and set us at research. I do not belittle research, by any means. I would point out that some people are research-minded and you

cannot keep them from researching if you try—which of course you don't. They should be encouraged. It was in the Central Islip State Hospital that the brain slides were cut and stained showing once and for all that general paresis is a form of syphilis. Probably the ward physician I have been describing has an original idea now and then and collects observations to support it. He should do so, and I predict that in any hospital represented here, his study would be welcomed and resources would be put at his disposal to push the study farther.

In this connection, the physician should be called on to bring together his observations and to formulate on paper his conclusions about the clinical facts that impress him in his daily work. If the hospital staff is properly organized, he will be called on regularly for such reviews. Otherwise I suppose we should say that it is his eighth responsibility to make such reviews independently and take them to his professor of psychiatry in his medical school for an opinion and friendly criticism.

After you have studied, struggled over, and perhaps suffered defeat on some measures that you believe good for your patients, you are stirred to think that some day it would be pleasant to sit where you could give the orders. That means administration. To most of us it seems natural for one physician to relieve another who is on the next higher level of responsibility in case of sickness or absence, and thus accustom himself to the problems higher and higher in the organization. I think we can call it a responsibility—the ninth responsibility—of the ward physician to know enough about how the hospital is run so that in case of disaster that suddenly left him in charge of all or a large segment of the hospital, he would not be unacquainted with what to do about requisition, supply, transportation, and the like.

Courses are set up to consider the problems of management. Under the theory of hospital administration that has prevailed lately in the Veterans Administration, no physician could take the course in administration given occasionally to the chief clerks. This winter we got the administrator's promise that the course will be thrown open to assistant physicians. The medical men in the state service, on the contrary,

are welcomed on their way up the ladder, and take an examination for each promotion.

Our ward physician will after a while wish to give some of his attention to the things he needs to be able to talk about in case of promotion, and he will study them with the same meticulous faithfulness that we have intimated in connection with his other duties.

We have now reviewed the principal responsibilities of our ward physicians under nine categories: He must know his patients, assure them of proper treatment for their intercurrent ailments, constantly study their states of mind, provide whatever measures will improve their mental conditions, participate in public education in questions of mental health, make documentary reports of his observations and clinical conclusions, prepare himself for administrative responsibility; to these seven we have added two conditional duties—that of participating in research if his type of mind suits him for it, and that of doing outpatient work if his organization permits.

I have outlined these responsibilities and duties, picturing the ward physician as a gentleman, a scholar, and a scientist all in one. I have noticed some evidence of amusement and skepticism on certain administrative faces here, and awe on the countenances of some others. I challenge you to tell which character and which duty to omit. Where, you demand, does one find such men? In books, I reply. But in this outline I have shown ward physicians some accomplishments that perhaps they will wish to add to their present achievements. And I may have pointed some administrators toward some of the many opportunities that his assistants want for study from year to year.

It is to be hoped that you can arrange them all. Indeed I may be carrying anthracite to Scranton, for with your huge organizations here on Long Island, you may be teaching every one of these techniques to all your assistant physicians. What I have laid down might take ten years of training. And then the higher authorities grasp your well-trained ward physician and make him clinical director at Gowanda or Fort Lyon! My sympathies go out to you.

In 1873, Dr. Isaac Ray, of Butler Hospital, read to his fellow superintendents an essay entitled, *Ideal Characters of*

the Officers of a Hospital for the Insane. He permitted himself some whimsicality, saying that his was a dream. He had been reading on a Sunday the Reverend Thomas Fuller's essays on the good merchant, the good judge, etc., written in the days of Charles the First. He had also read, he said, a pile of reports from mental hospitals. So here are some of the things he wrote—or dreamed—about "The Good Assistant Physician." He "is never at a loss for occupation, and his constant thought is, not how little, but how much he may do. His heart is in his work. . . . He learneth the circumstances of each patient . . . and watcheth the effect of remedies, amusements and work. . . . He spendeth much of his time with the patients—not those only who are somewhat capable themselves of contributing pleasure, but those, less agreeable and more inert, who might derive some gratification from his efforts to entertain. . . . He inspireth them with confidence in the measures taken for their benefit. . . . By frequent conversation and other intercourse with them, he discovers their varying humors, their predominant desires, their new delusions, their plans and projects. . . . He disdaineth to magnify himself. . . . The hospital he regardeth as a school of instruction, and he diligently availeth himself of the lessons it is ever ready to teach. In recording the cases he strives to be full without redundancy and brief without being meager. . . . He studieth in connection with his particular observations, the works of famous writers, whereby he discovereth relations and analogies that greatly magnify the value and scope of his own personal results."

So much from the pen of our distinguished predecessor, Isaac Ray. You see that he covered the subject more succinctly and better than I have. If our assistant physician will do as well as Dr. Ray asked, neither I nor anybody in Washington will have occasion to find any serious fault.

SOCIAL BACKGROUND AND SOCIAL INTEGRATION OF THE PSYCHIATRICALLY ILL CHILD IN CONGREGATE TEMPORARY-SHELTER CARE

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THIS paper is concerned with the emotionally ill child who needs psychiatric service in a congregate temporary shelter. The 200 unselected cases discussed here were in residence at the Children's Center of the Department of Welfare of the City of New York. This institution is a nonsectarian, interracial, publicly operated shelter for dependent and neglected children between the ages of two and sixteen years. It has accommodations for 356 children, and there is an annual population turnover of approximately 1,780 children. However, because of difficulties in securing appropriate foster care, nearly two-thirds of the children in residence remain beyond a temporary period of care, some for as long as two or three years.[1]

At the center, a child is referred for psychiatric examination by the social-service department if disturbed behavior is observed by the social worker, the children's counselor, the teacher, the recreation worker, or the pediatrician. Other children are seen when significant facts about their emotional disturbances are known before their admission to the center.

The orthopsychiatric personnel at Children's Center consists of one chief psychiatrist, 10 hours per week; one associate psychiatrist, 10 hours per week; one director of social

[1] See "Preliminary Report on a Psychiatrically Focused Program of a Temporary Shelter for Dependent and Neglected Children," by J. J. Murphy, J. A. Simmons, W. C. Hulse, and M. C. Vargara. *Journal of Child Psychiatry*, Vol. 2, pp. 285–301, 1952.

services, full time; seven psychiatric case-workers, full time; one director of psychological services, 10 hours per week; one clinical psychologist, 10 hours per week; and three clinical psychologists in training giving a total of 45 hours per week. In addition, a child-guidance team from the Manhattan State Hospital, engaged in a special experimental and training program, was in attendance two half-days per week in 1951 and 1952.

In New York City, during the year 1952, there was a daily average of 1,157 dependent and neglected children in temporary-shelter care. All 15 shelter-care agencies in New York City, except Children's Center, are operated under private voluntary auspices, and their intake can be controlled. Children's Center, as a public agency, cannot refuse shelter to a child in need. As a result, most of the children who present psychiatric problems at the time they are referred for temporary-shelter care are admitted to the center. The only exceptions are those children who have been diagnosed acutely psychotic, or who are grossly defective. It should be noted that until January 1, 1953, the residential-treatment facilities for seriously disturbed children in New York City were extremely limited and, as a consequence, the psychiatrically ill child at the center remained in temporary-shelter care for excessively long periods of time.

The 200 cases are evaluated according to reasons for reference, past history, symptomatology, and diagnosis.

This paper is concerned with the types of psychiatric disturbance found in a congregate children's shelter and the backgrounds of the children that contributed to these disturbances. The specific difficulties of shelter care for the emotionally ill child and the difficulties in placement are discussed. Suggestions are made for a more adequate placement of children of these types.

Case Material.—Of the 200 children included in the study, 108 were boys and 92 girls. This distribution conforms to that of the general population of the center, wherein the number of boys was slightly higher than the number of girls.

The reasons for referring children for psychiatric study were: (1) an unusual amount of aggressive, hostile behavior—

e.g., gross acting out, such as stealing, running away, fighting, and open sex play; (2) manifestations of withdrawal or depression; (3) numerous physical complaints without medical confirmation; and (4) unrealistic and bizarre behavior.[1]

Past history pointed to some interesting data which are presented in the following tables:

TABLE I.—PROLONGED ABSENCE OF ONE OR BOTH PARENTS *

Reasons for absence	*Number of instances*
Separation (incompatability)	59
Death	51
Illegitimacy	51
Mental illness	51
Severe physical illness (TB, cancer, etc.)	49
Long-term imprisonment	8

* Parents were living together in only 13 out of the 200 cases. There were frequently several reasons for parental absence.

TABLE II.—ASOCIAL BEHAVIOR IN PARENTS

Associated behavior	*Number of instances*
Alcoholism	57
Neglectful father or mother (court adjudicated)	37
Promiscuity or prostitution in mother	26
Criminality	8
Other asocial behavior	7

TABLE III.—AGE-GROUP DISTRIBUTION OF CHILDREN

Age group	*Number of children*
Pre-school	5
6–10	77
11–13	66
14–17	52
Total	200

Of the 200 cases selected at random, 44 had had previous psychiatric histories; 37 of them had been diagnosed as psychoneurotic, primary behavior disorder, character disorder, and so forth.

According to diagnosis, the 200 cases were grouped into the categories shown in Table IV:

[1] See "'On the Spot' Psychotherapy in a Children's Institution," by W. C. Hulse, R. Whitfield, and M. C. Vargara. *Psychiatric Quarterly Supplement*, Vol. 28, 1953.

TABLE IV.—DIAGNOSTIC CATEGORIES

Diagnosis	*Number of cases*
Psychoneuroses	85
Primary behavior disorders	71
Character disorders	23
No gross psychopathology	10
Organic illness	5
Psychoses	4
Mental deficiency	2
Total	200

The low number of psychotic, organically ill, and mentally defective patients can be attributed to the fact that cases of these types are usually weeded out early for hospitalization or other institutional placement. When they are clinically identified at the point of admission, they are not retained at the center.

The cases in our study fall into the following I.Q. groupings:

TABLE V.—INTELLIGENCE GROUPING OF CHILDREN *

Retarded	*Number*	*Normal or above*	*Number*
I.Q. below 60	2	I.Q. 90– 99	42
" 60–69	9	" 100–119	12
" 70–79	31	" 120–130	2
" 80–89	47	Above 130	2
	89		58

* In 53 cases no data were available on intelligence as the children left the center before psychometrics could be completed or were too disturbed to be properly evaluated.

Illustrative case material is herewith presented to show types of family background and behavior problem in the cases that come to the Children's Center. These are typical examples.

Case 1.—Alvin, a six-year-old boy whose behavior varied from a very lovable, coöperative attitude to a violent, aggressive one, was subject to frequent temper tantrums in which he screamed, kicked, bit, and attempted to destroy anything within his reach. He was referred for a psychiatric work-up. His tantrums were extremely upsetting and frightening to the children in his group.

A., with his siblings—R., five, and H., three—all of illegitimate birth, were referred to the children's court by the Society for the Prevention of Cruelty to Children, which initiated a neglect petition that was adjudicated by the court. The children's mother had separated from the father because of his excessive drinking, only to take up another illicit relationship with another alcoholic who, under the influence of liquor, was abusive to wife and children.

This mother had been surrendered for adoption when only a few months old, had been placed in an adoptive home, but had been returned to the institution, only to be subsequently placed in two adoptive homes, six boarding homes, and two institutions in New York State. Coming to New York City in 1943 at the age of sixteen, she went to a girls' resident club, but was so disturbed that she was sent to Bellevue Hospital and later to Rockland State Hospital with a diagnosis of "psychopathic personality with psychosis." She had remained at Rockland State Hospital until July, 1944. Out on parole and receiving public assistance, she had lived with different men. She was unable to assume proper care of children and home. Before the neglect petition was finally instituted in 1951, she had conceived again in an out-of-wedlock affair with another alcoholic man.

The mother, a white woman, was very ambivalent toward Alvin, who had been born of a Negro father. The boy's developmental history was not significant except that he was always described as being "hyperactive."

Case 2.—Barbara, a thirteen-year-old girl, was referred because she had made a poor adjustment to the center and to the "outside" school. She was described as having wide swings in moods—alternately quiet and withdrawn, and impudent and indolent. She was a truant, quarrelsome, disobedient, and subject to temper outbursts. In addition, she had disabilities in reading and arithmetic. The older of two girls, B. had been exposed to constant social, economic, and emotional deprivation. The father had deserted when she was a small child. Her mother and grandmother, with whom she had always lived, were alcoholic and engaged in other forms of asocial activity. The mother was subsequently committed to a mental institution, and placement in temporary shelter for the children was effected, pending placement in foster care.

Case 3.—Charles, a sixteen-year-old boy, was referred because he had begun to show signs of restlessness and expressed a desire to be alone. He resented being with a group after having spent six and one-half years in another institution for boys. Anxiety about his academic difficulties was evinced. He had become quick to anger, and would fight at the slightest provocation. C. was the older of two siblings. The mother had divorced her first husband after one year because of infidelity. Seven years later she had married Mr. X. (C.'s father), but after one year had separated from him because of his drinking. Three years later, she had taken up a common-law relationship with Mr. Y., who had met a violent death by stabbing some eight years later.

After C.'s birth, Mrs. X. had suffered a depression and had been picked up by police when she had attempted suicide by trying to jump into the Harlem River. She had been admitted to a state hospital and released the same year as improved. She had returned to her legal husband, Mr. X, and given birth to a second child. Eleven years later she had sought placement for the children, saying that she was having a "nervous breakdown." Two months later she had committed suicide by turning on the gas in her apartment.

Case 4.—Delores, a twelve-year-old girl, was referred because she appeared tense and restless, was unable to relate to adults, was unkempt

in her personal appearance, was unable to converse with her mother when she visited, and showed difficulty in functioning in the group.

The mother was negligent of the children and an alcoholic. She had had seven out-of-wedlock children. She had once married, but had separated after two years. The children were aware that the mother's paramour had killed her brother. One sibling had actually witnessed the slaying by this man, with whom the mother continues to have a relationship. Charges against the paramour were dismissed by the court.

Case 5.—Edward, an eight-and-a-half-year-old boy, was referred for a psychiatric evaluation because he was unable to relate either to adults or to his peers. He was excessively withdrawn, appeared unhappy, and was given to thumb-sucking, nail-biting, and daydreaming.

His father and two siblings, ages seventeen and nineteen, visited him infrequently, because of work schedules and distance. His mother had been confined to a state hospital for chronic tuberculosis for three years. During this period, he has never visited his mother, but has been shifted from one relative to another.

Our case material shows uniformly severe neglect by parents who are seriously disturbed and unable to maintain for themselves and their families even a minimum of social standards. They are disorganized, violent, delinquent, and physically or mentally ill people who are unable to care for themselves and are, therefore, incompetent to bring up children. The five case histories given high-light this common background of the group of 200 children discussed.

All 200 cases presented severely disturbed and traumatized backgrounds. We feel that this material is significant on the basis of experiences gained at Children's Center. Such experiences have not been high-lighted elsewhere.

The general population of the center has been further investigated by four studies entitled, *A Survey of Problems Presented by Dependent and Neglected Children in Residence at Children's Center.* Identical methodology was used in all four studies. One of the ten specific problems identified in the studies was the seriously disturbed child for whom psychiatric care is recommended. On May 9, 1951, there were 68 (18.9 per cent) such children in residence at the center; on November 28, 1951, there were 80 (24.2 per cent); on May 14, 1952, there were 82 (22.7 per cent); and on November 12, 1952, there were 87 (26.1 per cent).

The majority of the seriously disturbed children identified in the four studies have suffered from lack of proper family care due to severe physical or mental illness or delinquent

behavior in the parents. They should, therefore, not be returned to their parents until adequate rehabilitation of the parental home has been achieved. In most instances, the parents presented severe psychopathology in their own lives. On the other hand, most foster-care agencies are reluctant or unable to accept children who are emotionally disturbed, particularly if these children have excessive educational disabilities.

In an attempt to make available to all seriously disturbed children the facilities of Children's Center, these children were classified into three broad categories for the purpose of screening and selecting them according to their treatment needs and their probable response to environmental manipulation and orthopsychiatric disciplines. For the 87 children identified as seriously disturbed, for whom psychiatric care had been recommended in the November 12, 1952, study, the following categories were established:

A. *Moderately Disturbed* (39 children).—This type of child can respond to a carefully directed and psychiatrically oriented group-living situation, requires a minimum of regimentation, and can be integrated into the community life of school, church, and leisure-time activities away from the institution. This child can respond to individualized care given by a counselor who is warm, intelligent, understanding, and able to absorb aggressive behavior. Integration of the child into the total program is achieved through close liaison between the counselor and the psychiatric social worker. Individual psychotherapy is *desirable*, but ***not absolutely necessary*** for this type of child.

B. *Difficult* (37 children).—These are children whose needs are such that they cannot be completely met in day-to-day group living. This type of child requires, in addition to the setting described in "A," special individual, psychiatric treatment. The process used at Children's Center is as follows: The child is seen regularly, once a week or more often if necessary, for individual psychotherapy sessions of from 45 to 60 minutes duration, by a professional person (psychiatrist, psychiatric social worker, or clinical psychologist) who works with the child under the supervision of the chief psychiatrist, generally over a period of three months, but often

for a period of from six to ten months. The cases of all the children under treatment are reviewed regularly in conference with the director of social services, the director of psychological services, and the chief psychiatrist. The therapist, case-worker, psychologist, and psychiatrist remain in close liaison with the institutional staff and school, in order to coördinate the psychotherapeutic and environmental management.

C. *Extremely Disturbed* (11 children).—A child of this type requires frequent temporary restriction and constant close supervision in the group-living situation. Regular control is necessary at all times and all program activities have to be confined to the limited area of the institution proper. Control is required as an adjunct to the therapeutic procedures described in "A" and "B."

At Children's Center there is a firm belief in the concept of a balanced population. We apply this concept not only to the three above described categories, but to all children in residence. Experience has taught us that within the generic description of congregate temporary-shelter care, the children need not be of the same sex, the same race, the same intellectual capacity, the same background, or the same type of behavior pattern. We do not presume to assess arithmetical percentages as to how a balanced population should be achieved. Each facility will have to make an analysis of its own resources and construct its own formula to fit the particular set of circumstances inherent in its total program.

In consequence, we feel that the emotionally disturbed child can be absorbed into a total group-living experience, providing the total program has an orthopsychiatric focus in which the specialized services are used in consultative capacities and for the orientation of the total staff. We came to this conclusion as a result of careful evaluation of controlled surveys.

At Children's Center, there is a recognition of the practical reality of operative problems, such as lack of control over intake, limited facilities for diagnostic work-ups, insufficient services for the number of children who require psychotherapy, and a lack of proper balance in both primary and interest grouping of children. However, despite these limitations, Children's Center has tried to demonstrate that all

group-living facilities can admit and accommodate seriously disturbed children if they can provide adequate orthopsychiatric disciplines. We hope that our experiences will encourage those institutions that are now hesitant to admit emotionally disturbed children to open their doors to a limited number of such children and to adjust their total program to the needs of these children.

To summarize, a survey of 200 children who came to the attention of the psychiatric services at Children's Center, Department of Welfare, City of New York, shows that 93.5 per cent came from broken families, in which rehabilitation of sound and adequate family living appeared impossible in the foreseeable future. While the diagnostic categories and the distribution of intelligence among this group of children do not show any unusual features, their behavior creates management problems in an open shelter for neglected and dependent children. Children's Center has developed a psychiatrically oriented program focused on the integration of all disciplines. This program has been described in a previous paper.[1] The present paper focuses on another stage in the development of a psychiatrically oriented program—namely, the integration of emotionally disturbed children in the general population of a congregate temporary shelter.

In an attempt to meet the needs of all seriously disturbed children with the facilities available within Children's Center, the children were classified into three broad categories for the purpose of screening and selecting each child according to his treatment needs and his probable response to environmental manipulation and orthopsychiatric disciplines. It is hoped that other group-living facilities which at the present moment are hesitant to accommodate seriously disturbed children will be encouraged to provide orthopsychiatric disciplines as developed in Children's Center.

[1] See Murphy, Simmons, Hulse, and Vargara, *op. cit.*

IMPLEMENTING MENTAL HEALTH IN THE SENIOR HIGH SCHOOL

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EACH individual has four ages—the chronological, the physical, the mental, and the emotional. Mental hygiene is most concerned with the emotional age. Chronological age takes care of itself. In the past parents and teachers have been most interested in the physical and mental development of our young people. Very little interest has been shown in the proper development of the emotional age by any one except, of course, by the psychologist and the psychiatrist.

It is, however, most important that we keep these four ages moving together. No one of them should be "out of step" with the others. No one wants to see a high-school boy or girl behaving like a six-year-old. It is even worse to observe adult behavior that is immature. The home and the school are the logical places in which to emphasize the *proper* development of the emotional age along with the physical, the mental, and the chronological.

For the past two years, Psychology II, an advanced study of psychology in the science of mental health, has been offered to seniors in Central High School in Oklahoma City. This class has developed as a result of student requests for more education in mental hygiene. To enroll in the class, one must be a senior and have completed one semester of psychology. Mental health is a one-semester course, granting one high-school credit.

The mental-health goal of this class is to increase the happiness and efficiency of its individual members. Dr. Schoolland, Colorado University professor of mental hygiene, has remarked that "each of us has observed that some people are happy, but not efficient; some people are efficient, but not happy; and too many people are neither happy nor efficient in their work." Early in this class the students become aware of the problem.

Dr. William C. Menninger, speaking to the National Congress of Parents and Teachers recently, stated that "emotional

illness has a ratio of one to one. We all have our emotional problems. We know that parts of us grow up and parts of us do not grow up. Some housewives keep a spotless home, but they do not know the first thing about making love. Some people become business wizards and misfits socially."

In this class in mental health the work is built around the philosophy:

Know thyself.
Accept thyself.
Be thyself.

This seems to be an adequate philosophy, since mental health is determined by (1) how you feel about yourself; (2) how you feel about other people; and (3) how you meet your problems every day.

The basic textbook for this class is *How To Keep A Sound Mind,* by Morgan. However, each student is required to keep a scrapbook consisting of recent articles on mental health. Some of the units of study include the history of the mental-health movement; personality problems, such as inferiority, insecurity, fears, and emotional control; vocational problems; marriage and family problems; and problems of the handicapped. Great interest is shown in presenting class panels. Various types of test are used to measure improvement in the students' mental health.

If properly guided, group therapy contributes to improvement in emotional development. Louis P. Thorpe, in his book, *Psychology of Mental Health,* mentions that "directive interview therapy has been used successfully with individuals suffering from *minor* maladjustments, psychoneurotic disorders, or psychosomatic conditions." However, no teacher should deliberately pry into the personal background of a student. Every student has a just right to reserve his innermost thoughts and feelings; yet he desperately needs to have confidence enough in some one to "tell his story." Teachers must gain rapport with their students in order to be of assistance. Then, by all means, a teacher should take some action in regard to the student's problem.

Catharsis and reassurance are splendid means toward re-education. One of the students in the mental-health class remarked one day, "What I like best about this class is the way we take an idea and 'kick it' around."

A boy entered the class very much disturbed about himself. He felt that he simply had to express his feelings to some one. He asked, "Do you think that I am a spoiled brat? Every teacher has told me that to-day—even the boys' counselor and the principal."

Also, I distinctly remember the class discussion that followed when a girl insisted, "My mother is not altogether to blame for her children's behavior. Parents cannot be to blame for everything." What opportunities for a lesson on the philosophy that *you do not have to be perfect!*

This mental-health class has found many opportunities for civic participation through the Oklahoma state and county associations for mental health. Representatives of the class were sent to the associations' meetings in order to report their findings to the class. For example, great class interest centered around a panel presented by the Oklahoma County Association for Mental Health on the subject, "Oklahoma County Youth To-day."

Last year twenty-five students in the mental-health class planned and presented skits and a panel for the Oklahoma Association for Mental Health under the title of *The Mirror of Youth.* The theme for this program was "Insecurity and Inferiority." When the play, *My Name Is Legion,* was presented, twelve students assisted as ushers. Other students appeared on the program during the membership drive for the Oklahoma County Association for Mental Health.

Other activities of the class included securing speakers from the mental-health association, obtaining visual aids, and making field trips. The visits to the School for the Mentally Retarded at Enid, Oklahoma, and to the Central State Mental Hospital at Norman, Oklahoma, were worthy projects. Dr. Cannicutt, psychologist at Norman, presented typical cases of the mentally ill and discussed causes, treatment, and prevention. He made a great impression when he emphasized that it is more important to prevent mental illness than to be so concerned about mental illness that has already occurred. All members of the class felt that these trips were more important than any textbook lesson they had ever had. However, just a word of caution: since there is danger of psychic trauma, it is not wise to pressure students into taking such a

field trip. Also, it would never be a good school policy to take any classes other than those who have made some study of mental illness.

At the close of the school year of 1953, two fifty-dollar scholarships were awarded members of the mental-health class by the state and county associations for mental health. These were given to encourage young people to continue their college education in the field of mental health. In addition, a certificate of honor was given to the class in recognition of their leadership in the field of mental health. This is a framed certificate and is to remain in the classroom as an incentive to other psychology students.

The school has three major approaches to mental-health problems—remedial, preventive, and developmental. In the remedial approach, the objective is to refer *severely* maladjusted students to the psychiatrist for treatment. All teachers should be well enough informed about mental illness to recognize cases that should be so referred. A formal class in mental health is no place for a student who is severely maladjusted. If some one has cancer, it is unwise to hand him a book to read about his physical illness. He needs a doctor. Information about an illness is one thing; therapy is quite another.

Primarily the emphasis in every classroom should be on the preventive and developmental approach to mental hygiene. Mental hygiene need not be confined to study in a formal class. All teachers should help in the improvement and the development of the student—physically, mentally, and emotionally. A better understanding of the science of mental health may be the answer to many of the school's problems.

If mental health is to be included in the curriculum, what are the problems? Basically, they have to do with the attitudes of the doctors, of the parents, and of the teachers themselves. Some psychologists and psychiatrists feel that this is an area into which no *teacher* can intrude. They admit that group therapy would be a splendid idea; however, teachers are not prepared for this kind of work. Yet we all know that teachers go right along every day counseling hundreds of maladjusted students. With more assistance from the psychologists and the psychiatrists, teachers may be a great help in giving some relief in this "troubled world."

On every hand to-day there is much discussion about the proper teaching of "the three R's." Most of the people who are critical of modern education really know very little about education as it is in our American schools to-day. They should take time out and go to the schools to see for themselves. For example, in the mental-health class there is a broad field for reading. In fact, bibliotherapy will greatly aid in personality adjustment. Writing is most helpful in catharsis. Writing a class paper on such a topic as "My Personality Problem," "What I Fear Most," "My Philosophy of Life," is a splendid way of "getting it off one's chest." Then in the field of statistics there is no better place to make practical application of mathematics.

As for the teacher, there seems to be a variety of opinions. Chiefly they have to do with lack of information or misinformation in the field of mental health. Many teachers are just subject-matter teachers; many are still preparing the children for college only. These teachers find no time for emotional development in their classrooms. Some teachers feel that a formal class in mental health is remedial only; therefore, all maladjusted and problem students should be placed in the mental-health class. Few teachers know about the three areas—remedial, preventive, and developmental. Our teachers should recognize that there is a place for a formal class in senior high school which can, in addition to the areas mentioned in mental health, give an educational foundation for our future doctors, nurses, teachers, business leaders, and parents.

Much help can be given by the school counselor to the severely maladjusted and border-line cases. The counselor should refer such students to the psychologist for testing, and should make a wider use of the school's outlets in psychotherapeutic methods, such as art, music, athletics, and constructive handicraft.

More mental-health education for all teachers would help to solve all of these problems. Psychiatrists and psychologists should come out of the clinic to assist the teachers in this broad educational program. Parents, teachers, and doctors, uniting together, can greatly improve our present school program.

A THEORETICAL FORMULATION OF PLAY AS LIFE EXERCISE

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A PSYCHOTIC patient, listening and talking to voices, suddenly picks up a golf club, stops talking and listening to hallucinations, and concentrating on hitting the ball, executes a skilled and intelligent movement. Another mental patient, giving expression to exaggerated and uncontrolled behavior, walks up to the bowling alley, grabs the ball, and gaining a pattern of bodily control, accurately propels the ball in a finely controlled movement. Still another psychiatric patient, in a deep depression, suddenly lights up with an expression of interest as he catches a ball thrown to him. An overly important patient, experiencing the leveling process of group participation in a team game, gradually gives up some of his coveted egocentricity; while a quiet individual, whipped into a pattern of overconformity, suddenly begins to express himself and become aggressive. A timid patient, who rarely talks, gets up in an athletic smoker and talks quite spontaneously about his score in an activity in which he has taken part and which has become a significant part of himself.

These are some of the recognized phenomena of the unloosening by means of play of inner forces which, operating predominantly upon the sensory levels, exert profound influence upon human behavior. How can we account for the recognized fact that psychotic patients in a play relationship exhibit more normal behavior than in formal situations? It is the purpose of this article to attempt a discussion of this question through examination of a fundamental concept of play which may serve to explain partially, at least, some aspects of a modality and its impact upon medicine, psychology, and society.

There are many concepts of play, from the conventional meaning, to amuse or divert oneself, to engaging in a game,

or behaving in a certain way as in playing fairly, acting in or on the stage, pretending to engage in an activity, and contending, as in a game of football. Then there are other applications of the word, as in playing an instrument, and some unusual usages, such as the definition to vibrate swiftly as "grasses play in the wind." Moral implications come into the definition, as relating to gambling, playing the horses, playboy. One speaks of playing hard, for example, hitting the line hard in football, and at the other extreme, of toying with and touching lightly. Play, being but a slice of life, has many such wide and deep connotations in the psychosocial, psychosexual, and psychophysical areas.

When one attempts to account in any systematic fashion for the hygienic aspects of play, one is able to pick out from its various characteristics different ones to account for variant results. For example, the ease with which the aforementioned hallucinated individual sublimated the voices while hitting the ball might be explained as a skill hunger which allowed him to evoke and utilize a relatively high degree of interest in the normal act of hitting the ball, which more or less crowded out the voices from consciousness; or there is the more social interpretation which takes into account the feeling of the patient that he must pay attention to the ball rather than to the voices if he is to win and gain the satisfaction of being considered worthy of his fellows.

It is perhaps best to seek a more general and inclusive concept which may provide the basis for an orientation of the meaning of play in these various hygienic relationships. The term "life exercise" is proposed for this purpose. By life we mean the quality or character that distinguishes an animal from dead organic bodies; by exercise, we mean the use of vital activities, animate existence, as in the phrase, "to bring to life." According to this definition, play and life are almost synonymous, and together they produce biological, social, and psychological phenomena pertinent to a better understanding and functioning of human behavior and personality.

When Jacks spoke of the ideal climate in which the "playground of the body becomes the playground of the soul," he projected another fundamental component of play in its

social and spiritual irradiations. In attempting to define the animating principal of play, we frequently refer to the "soul" of the experience, as the essence, the actuating cause. We think of the soul as the seat of life, as life manifested in thinking, willing, and knowing. In seeking an explanation of the high spirit with which an individual may devote himself to a play activity, one frequently refers to such vital elements as courage, fervor, spirit. College team play, for example, may, as a result of pep rallies, become a strong spiritual force.

When one attempts to evaluate the æsthetic dances of a people or race, still another component comes into the psychological mosaic—the element of culture, the enlightenment and refinement of taste acquired by intellectual as well as æsthetic training. One may see in such dances the particular stage and advancement in civilization of a people, or the characteristic features of such a stage or state as the primitive Greek or German culture. When play becomes the nice thing to do, it then becomes a part of the culture of existing society. The coöperative motif may provide the motivation for play, as well as the competitive motif, and as these conjunctive elements permeate the experience, play becomes cultural and part of the cultural development of society.

The concept of life exercise, therefore, spreads out to touch just about all significant experience as expressed upon the phylogenetic, sensory, verbal, and intellectual levels, and permeates the social and cultural areas. The unique effectiveness of play as a contribution to human welfare may well be its distinctive quality of integrating these life forces into a medium that is both natural and pleasurable. The naturalness of the play action is recognized to be one, if not the primal, element in its scientific value as an adjuvant in psychiatric treatment.

There is still another important element in play—its lability for modification and progression to meet specific treatment aims. One can visualize a trinity—exercise advancing to activity and thence to rehabilitation, as illustrated by the experience of the paraplegic patient who utilizes physical exercise to strengthen the shoulder girdle to gain strength to support his body on crutches for the secondary

purpose of learning the activity of ambulation, progressing thence to the third stage, rehabilitation, through which he may be able to engage in useful work. Underlying this process of physical restoration is an emotional experience in which the glowing images of self-dependence motivate him to make a great effort to surmount a profound trauma to his physical, mental, and spiritual being.

It is in this psychosocial area that exercise becomes life and the concept of life exercise emerges in clearer outline. Neurologists call attention to many paraplegic patients whose regained ability to function cannot be explained upon the basis of the intact neural pathways, but can be understood only when one recognizes the powerful excitants and integrants that exercise as related to life itself can produce. It is this X quality, largely unknown and unexplored, that provides one of the most intriguing problems for medicine and psychology in the modern quest to utilize and develop play and play areas as treatment.

Adolf Meyer, who stressed the sensory levels as areas of treatment, spoke of what the patient does *"sua sponte"*—in response to his own nature—as significant in understanding him as an individual. Spontaneity as an inherent characteristic of play undoubtedly accounts for much of its allure. We are reminded that this quality represents "raw behavior" and that it provides a firm genetic basis for an understanding of the early determinants of behavior. The spontaneities of the play phenomenon account for much of its ease and naturalness and provide a quality that will motivate the participation of many negativistic patients. The sheer physical abandon allowed in spontaneous physical activities provides another important component of therapy, as illustrated by the resistive psychotic patient who made his initial participation in therapy through a dance activity. When asked the reason, he explained that the dance was the only activity he could carry out just the way he wanted to.

The concept of play "as moving swiftly," as grasses play in the wind, may be related to its phylogenetic basis as an actuating principle of life. Life is characterized by movement, and the swifter the movement, the more life. It is this concept of abandon, illustrated by the grasses vibrating

in the wind, that explains some of the inherent zest in play experiences. The playing of the fountain in discharging and ejecting reflects its psychosexual character. It focuses attention upon one of play's most pregnant therapeutic potentials —its significance for catharsis. In play, emotions find relief through discharge into sensory channels.

Still other psychological aspects of play are shown in such softened activities as toying with an object, touching it lightly to modify the sensory experience with the less pressing requirement of living. Another softened approach to life through play is developed when one "acts" in a play. In this situation, the play folk escape direct responsibility for their actions, and may in a sense strengthen their hold on reality while engaging in phantasy.

It is a commonplace to observe that, both in humans and in subhumans, play is the medium through which the infant makes contact with his environment and becomes acquainted with life. At this stage, the learning process takes place that adults call play, but that the child knows as life. Basic motor patterns are established which underlie both the child's later activity patterns and his basic attitudes. As the child grows older, his activity patterns become more and more complex and lead to the development of adult mechanisms of work, etc. He exercises more restrained effort to reach goals and these efforts are invested with added responsibility, gradually merging into the work experience. There is always, however, in adult life the refreshing effect of simpler activity patterns which have become identified with the early childhood play. These life qualities persist in the normal development sequence, to vitalize the play experiences of the adult.

A theoretical formulation of play as life exercise must take into account the fact that all life is not good, and, conversely, all of play is not hygienically wholesome. Just as one may play good or bad music on an instrument, play folk may express unwholesome feeling through their organisms. The psychotic patient who wants to beat the opposition to the point of psychic pain, who gains personal satisfaction from overwhelming his play partner viewed as an adversary, illustrates the point. On the other hand, those who view life in its richest social connotation as a coöperative enterprise

will naturally express in their play the related conjunctive feelings. A philosophy of play will seek to find the animating principle through an examination of its multiform manifestations, which bring unique qualities of life to enrich the play expression. The science and art of play as therapy will depend for its full development upon the ability of the therapist to extract from life experiences significant acts and facets that, in a pleasurable play medium, may aid in the development of constructive behavior, and, conversely, to select in the play experiences, the activities that are closely tied to the realities of sane and sound living. A concept of therapeutic recreation may also emerge in the re-creation of those pleasurable life patterns which prove to be constructive forces in the hygienic integration of personality.

HELPING THE FAMILIES OF OUR MENTALLY SICK

A HOSPITAL CHAPLAIN AND A HOSPITAL SUPERINTENDENT SUGGEST SOME OPPORTUNITIES *

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THE pastor of one of our former patients recently wrote that the patient's husband had committed suicide, and expressed the opinion that "he did it partly at least because of worrying about his wife." The patient's mother wrote, "When she was in there before, her husband was living to help me out, but . . . he lived in it until his nerves cracked up with him and he died from gas. . . . I understand, for I know he had been through enough. He could stand it no longer. I am her mother, and now I have it all on me. They have two children . . . I have those also."

This is illustrative of the many kinds of tragedy that may follow mental illness in the home. When one member of a family becomes mentally ill, others in the group will usually experience severe difficulties in living. These difficulties may be lessened considerably if some one is available to provide the right kind of help at the right time. If adequate help is not available, additional illness in the family may result.

Sometimes this additional illness seems to come about principally because the factors that are prominent in producing the illness of one member of the family group are operative for the other members also. What seems to be of even greater importance, however, is the additional *stress* that illness imposes upon a family. By the time the sick member enters a hospital, the strain upon the others has already been so great as to cause a considerable lowering of psychic

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resistance. And hospitalization itself, while solving some problems, creates others.

The typical picture is of a family whose most hopeful view of hospitalization is that it is the lesser of two evils. The members of the family have watched the development of illness, without being aware at first of its seriousness. Perhaps too late they have sought help from a physician or some one else in the community. They have managed somehow to live through a number of difficult days and nights, wrapping about them a garment of hope. Eventually their hope is worn threadbare or torn apart by episodes of increasing severity, and at last they recognize that hospitalization is the only answer. But while this relieves the acute distress at home, it does not heal the psychic injury already suffered by the family.

And hospitalization often marks the beginning of additional family stress. Where the illness is prolonged and runs a chronic course with acute episodes, bringing the family frequent alternations between hope and discouragement, the result may be more disruptive to over-all family living than even the finality of death itself.

Seven years ago a forty-eight-year-old woman spent a brief period in a private mental hospital. The husband, an unusually stable person, expressed his own despair in saying, "She will never come back." Although she did come back home after only one month and presently was able to take over both household and outside-work responsibilities, her husband said recently that it took *him* four years to "get over" his wife's illness. Now when she talks again about her symptoms and the possibility of having to go back to the hospital, the husband says he "gets all weak in the knees," and just does not believe that he can face much more of it.

In some instances, children will begin to worry about whether they themselves will become ill. Folklore, old wives' tales about "tainted blood," and misinformation readily garnered about heredity combine to increase the already heavy load that such people have to carry. One young woman became sufficiently concerned about her mother's illness to seek help soon after graduating from college. Her

mother had had a number of psychotic episodes, and had been in and out of hospitals ever since the daughter was a child. The daughter was seeking the answers to such decidedly non-theoretical questions as these: Was there a probability that she herself would become ill? If so, how would that affect her contemplated marriage? What are the facts regarding the inheritance of mental illness? If she did marry, should she have children? Furthermore, her physical distress ("butterflies" in her stomach) would become so acute that on several occasions she found it necessary to leave her work.

When we consider the ramifications of such problems, we are well-nigh forced to the conclusion that illness of one member of the family should be the signal to rally to the defense of other members of the family. Here is one of the greatest opportunities for preventive mental hygiene; here should be the most immediate concern.

Hospital physicians usually have neither time nor opportunity to take these preventive measures for the patient's family. Where is the psychiatrist to turn for assistance in meeting this vital need? The hospital social-service departments do work with families where they are sufficiently staffed to undertake service of this sort. But it is usually not feasible to visit these families frequently enough, or to provide the kind of care they need. It would be pointless to belabor the well-known shortage of psychiatrists and psychiatric social workers. What should be realized is that, all other considerations aside, it would be economically impracticable to train a large enough number of specialized personnel to render these greatly needed services.

Mental-hygiene clinics in the local community may be of considerable help; but there are not nearly enough of them, and often they have a long waiting list. Family physicians may also help, especially when they are psychiatrically oriented. Still, when physicians, social workers, and members of the clinic team do all that they can—as presumably they are doing now—the need is by no means met. Other resources must be discovered and developed.

A great and largely undeveloped resource is the pastor in the patient's community. When the pastor is properly

trained, he may make a significant, and in many ways a unique, contribution in ministering to the families of the mentally ill.

One considerable initial advantage that the pastor possesses is that he has a ready and altogether natural entrée into the homes of his parishioners. As is true when other illnesses occur, it is thoroughly in order for him to take the initiative in seeking to help these troubled families, even when they have not learned to turn to him of their own accord.

Much of the pastor's help will lie in the area of influencing the way people think and feel about mental illness. Families usually consider such illness a disgrace. The necessity of taking a loved one to a general hospital is cause for consternation; but if the same person has to go to a *mental* hospital, feelings of shame are added to those of intense concern.

In as much as such feelings are a reflection of dominant community attitudes about illness, the minister has the opportunity to approach the problem in two ways: he may help both the family *and* the community at large to accept mental illness as sickness and not as disgrace.

In the community the pastor will not need to conduct any organized "campaign" or "sound any trumpets before him" concerning a helpful attitude about mental illness. His sermons and other public statements will convey his attitude. If his vocabulary is free from such archaisms as "crazy" and "insane," and if his predominating mood is marked by understanding and acceptance rather than condemnation and shame, his helpful influence may be like that of the leaven that the woman hid in a bushel of dough until the whole lump was leavened.

Sometimes both the family and the community reject the sick person even when he has improved to the point of being able to come home if a favorable recuperative environment is present. Seldom has this community reaction pattern been more forcibly described than in Luke's account of the healing of the Gadarene: "Then people went out to see what had happened, and they came to Jesus, and found the man from whom the demons had gone, sitting at the feet of Jesus, clothed and in his right mind; and they were afraid. . . .

Then all the people of the surrounding country of the Gadarenes asked him to depart from them; for *they* were seized with great fear" (Luke 8:35–37). Why were *they* anxious? Did they fear another violent episode? Did they in some sense recognize, and yet not constructively accept, their own responsibility for this man's illness? Did they possess perhaps unrecognized feelings of guilt and shame which led them to reject the sick member even after he had been restored to health?

The same kinds of question have to be raised to-day. In some instances, intelligently conscientious members of the family may need reassurance that they are not to be "blamed" for the illness. In other instances, where the responsibility for the sickness must be shared, the pastor may help the family and the community to take a constructive point of view, so that they may learn from their experience and take adequate remedial steps. Here is opportunity for self-examination that does not condemn, and evaluation and clarification of family and community relationships.

In one household the father-in-law was completely uninhibited sexually, and became a source of increasing annoyance to his son's wife. This daughter-in-law endured the situation as long as she could and then became ill, while her husband was quite unaware of the strain under which she had been living. A major factor in her speedy and apparently complete recovery was an early visit from her minister, who assured her that he would talk with her husband and help him to take whatever steps were necessary to remedy this particularly unbearable aspect of their family life.

The minister also may help significantly in interpreting the illness and the hospital to the family. Not infrequently—and perhaps inevitably—psychiatrists leave unanswered a great many questions that trouble members of the family. Sometimes the psychiatrist's words may need to be interpreted, or even translated. A woman who has a master's degree in social studies insisted that the psychiatrist tell her the nature of her husband's illness. He finally said the words "manic-depressive psychosis." This usually placid wife was in tears as she telephoned her minister and asked, "Is that something *awful*?"

The pastor may often visit the patient in the hospital before visits are permitted the family. In this, or in other ways, he may secure firsthand information that will provide reassurance for the family about the welfare of the patient. In many mental hospitals patients are not allowed to have visits from their families for the first week or ten days, for the good reason that the illness may be so intimately associated with members of the family that seeing them may be quite disturbing. It helps the family during this period to have some kind of reassurance other than that the hospital will let them know if the patient becomes so ill as to be put on the "danger list."

As in other instances when people have serious difficulties, they may need the opportunity to ventilate their feelings, changing the psychic atmosphere. People need to air their hurts in the presence of some one who can be accepting and trustworthy. Some of the hurts are caused by words or actions of the sick member of the family, as when a sick person expresses great hostility toward others, and the minister can explain that such actions are symptoms of the illness.

On occasion, members of the family may need to be diverted from excessive thought about their difficulties. Encouragement to participate in other activities may be very useful. Some people *talk out* a problem; others *talk it up.* The trained minister will be able to tell whether talking about the family difficulties brings relief or whether it increases agitation.

When there are young children in the family, the minister may help in locating a suitable adult who will become the best possible substitute for the father or mother who is out of the home.

If the minister has maintained good contact with the family during the illness and has visited in the hospital, it is natural for him to continue the association after the sick member returns home. He may be of considerable value during this recuperative period. The former patient may need some interpretation of his home experiences, and may even need reassurance that it was an illness, and not something disgraceful.

Such assistance as we have suggested implies an attitude

of understanding and acceptance on the part of the minister, and, hopefully, also on the part of the church that he serves. The patient often feels rejected and unworthy, especially in terms of what he thinks the church stands for. When the minister approaches the sick person with understanding and acceptance rather than with condemnation, this fact alone may help immeasurably in restoring a valid sense of self-esteem which is so necessary for health. And where there are genuine feelings of guilt to be dealt with, he may help the sick person to find forgiveness, so that he can "go in peace," and perhaps even take up his bed and walk. Thus he will assist the patient, the family, and the entire community.

This kind of ministry is a present application of the historic rôle of *pastor*, the shepherd of the flock. In one of the fine phrases of the New Testament, the good pastor "*knows* his sheep, and calls them all by name." His function was stated as long ago as the writing of the book of Isaiah, in a passage quoted with approval by Jesus of Nazareth: "to bind up the broken-hearted, to set at liberty those who are oppressed . . . to comfort all that mourn, . . . to give unto them . . . the garment of praise for the spirit of heaviness. . . ." (Isaiah 61:1–3; Cf. Luke 4:18–19). The kind of *personal* association that exists between pastor and people in many communities provides the outward circumstance within which the fulfilment of this function is richly possible.

Whether this potentiality becomes a reality, with its large benefits to our patients, may depend mainly upon the vision, enthusiasm, and initiative of the hospital staff. It will depend also upon whether *both* ministers and psychiatrists can lay aside their mutual, and sometimes well-founded, suspicions and take up a fresh "let's see" attitude in the light of present facts. For either ministers or psychiatrists to persist in suspicious reactions toward the other profession *as a group* constitutes an anachronism in this generation.

Dr. Robert Felix, Director of the National Institute of Mental Health in the U. S. Public Health Service, has estimated that perhaps 40 per cent of the people take their personal problems first of all to ministers. The fact that so many people consult ministers speaks eloquently of the potential usefulness of this group in preventive and recuperative

mental hygiene. The fact that so many people still need help *after* consulting a minister speaks with equal eloquence of the need for more adequate pastoral training in interpersonal relations.

Already many ministers are recognizing the need for more adequate training in this field. Many theological schools include courses in pastoral counseling in their curricula. Still others, recognizing that "book-and-lecture-learning" alone is no more adequate for the minister than for the physician, strongly encourage their students to take a period of training in a hospital under the direction of the Council for the Clinical Training of Theological Students, the Institute of Pastoral Care, or some other training program. Many more students desire to receive training through these agencies than our training centers can handle. Such is the felt need of the rising generation of ministers.

Herein lies the hospital's opportunity. The minister is in a strategic position for influencing community attitudes about mental health. His historic rôle imposes upon him a helpful concern for his people, in sickness even more than in health. His intimate, personal association with his people makes possible a natural expression of this concern in ways that make for good mental health. There is almost no possibility that the minister will be a neutral mental-hygiene force in his community; his potential is too great, for either good or ill.

It is part of the hospital's job to make every reasonable effort to enlist the minister as a member of its far-flung therapeutic team. The key man in this enterprise may well be the trained hospital chaplain, who will of course work closely with the superintendent, the clinical director, and other members of the hospital staff. Both the chaplain and the hospital should become qualified for the training of theological students.

While the training of students for this kind of ministry is a special concern, we must not neglect the pastors who are already serving community churches. Many of these men welcome brief orientation and training programs given by the hospital chaplain and other members of the hospital therapeutic team. Even such limited training possesses great

potentialities for helping the hospital do its maximum for the health and happiness of its people.

Priests or ministers have worked at human problems at least as long as physicians have. Often grave errors have been made by both groups, especially when they have insisted upon going their separate ways. Socrates' long-standing charge that "the great error of our day in the treatment of the human body" is "that physicians separate the soul from the body" is actually a two-edged sword, for religion has often been as obsessed with "soul" as medicine has with "body." In these present days we recognize increasingly that "the part can never be well unless the whole is well." As the forces of religion and medicine work together, patiently, intelligently, and courageously, as members of one therapeutic team, substance may be added to the dream that a better era of healing is in store for mankind.

EDUCATION FOR MENTAL HEALTH *

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The National Association for Mental Health

THERE is probably no subject that engages the public interest as greatly as does mental health. Why not? Every one, minute by minute, in his feelings about himself, in his dealings with other people, and in his relations with the realities of the world about him, is happy, congenial, and successful, or the opposite, depending in large part upon his own mental health.

At the same time there is no subject that is likely to meet with so much hesitation as mental illness. Again why not? Every one knows himself better than he knows other people. He knows his failures, he knows that he is sometimes unreasonable, and he often suspects that his mental processes may not be entirely sound. Since he does not know other people as well as himself, he does not know about *their* imperfections and their qualms and anxieties. To him they look sounder than they are. A comparison is always to his disadvantage. He hopes that his mental health is not too far off base, and usually it is not, but since he is not sure, he would rather steer clear of the whole disturbing business, including those who are trying to give him information about mental health and mental illness. He shudders at the thought of a mental hospital, but in reality he is shuddering at his own imperfections. Would he be so concerned if he could accept the fact that "to err is human" and that the right to make honest mistakes is one of the earmarks of democracy?

This combination of interest and aversion in the attitude of the public is a major problem to those who are attempting to advance understanding of mental health. It cautions slow progress. The average citizen likes to feel his way along, taking small doses of education and not investing too much emotional risk all at once.

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Education, whether it be for mental health or for something else, is of two sorts. Sometimes education itself is the goal. Sometimes it is an instrumentality used to reach a well-defined goal of action that calls also for other approaches than those of education. But in general our schools and liberal-arts colleges follow the first purpose. They try to help a student to acquire a good understanding of the world without a clear definition of how this knowledge shall be used. They provide him with a foundation for dealing in an informed way with problems as they come along. In designing mental-health education, the first question that the educator asks himself is, "What knowledge have we?" and the second, "Which part of that knowledge has the more general use?"

For the second purpose, the content of the education is chosen with a nearer and more visible goal in mind. In that case, the first question is, "What change or condition do we want to bring about?" and the second, "What knowledge is needed by those who are in a position to bring it about?"

These two purposes of education are not as clear-cut as this distinction may imply, for a curriculum of professional education is often designed to help the student carry out some pretty well-defined functions.

On the other hand, too often this distinction is forgotten and purposes become confused. Sometimes a person or a group that is interested in promoting mental health will say, "Let us have a program of education in mental health," or even more specifically," Let us have some kind of film." They thus by-pass the first step. Instead, they had better make such definite statements as, "We need special provision for the mentally retarded or the mentally deficient in schools," or, "We need a child-guidance clinic," or "We need a psychiatric service in our general hospitals." It is clear that when the goal is set so specifically, one can begin to choose the knowledge that will best advance the purpose, but not before.

The evasion of a clear-cut purpose is not simply the result of a desultory approach to mental-health education. There is more depth and meaning to it than that. Vagueness is often safe. Education without a measurable goal cannot be checked up on, and so it can be rather seductive. Long reports are

often written about education that has been carried on, but one often has to guess the end that dictated particular lines of education. The results of such desultory education are so diffuse that they can never be measured. Education, therefore, can become a comfortable retreat. Since this confusion is more common with those who should be concerned with advancing community mental health than with those who are planning academic education, it may be well to look into education for social action. If such education is to be one part of a broader effort to reach a goal, certain steps may be followed to make sure that mental-health education has its proper place in the total scheme. What are these steps?

1. The first step is to decide what result is to be brought about. We shall call this the *goal.*

2. The second step is to design the strategy that will lead to the goal. We may call this the *plan.*

3. The third step is to identify the strategic persons that will be involved in the plan, and the rôles that these persons will play in the movement toward the goal. We will call this the *audience* and its *rôle.*

4. The fourth step is to determine what knowledge and understanding these persons need for their task. This includes a determination both of their present preparation and of what they need in addition. This is the heart of the educational efforts—the *message.*

5. The message cannot be transmitted indiscriminately through *any* media. Certain media are better adapted than others to carry a certain message to certain persons, and these media must be decided on. We will call them *channels.*

6. Finally, having carried the first five steps into execution, there is need to test the results, to determine whether the plan, the audience, the message, and the channels were successful in achieving the goal.

Now I would like to say something in detail about each of these steps and their bearing on mental-health education.

The Goal—The goal of mental-health education may sometimes be easily determined because it grows out of an acute current situation. This may be some form of delinquency. It may be an excessive amount of school failure. It may be a program that entails the separation of a large number of

children from their families. On the other hand, the goal may be determined more deliberately. A review of the full field is then necessary in order to arrive at priorities. Priorities are, as a rule, influenced by the relative seriousness of a need—serious both to the individuals involved and to society generally; by the extent of the need; by the state of our present knowledge about dealing with the need; and by the readiness of the public to give backing to the effort.

The Plan—Planning calls for a study of where we are with respect to the goal. What factors are at work in furthering or retarding progress? Research and experimentation may be needed. Planning may call for the organization of a committee or a group of citizens. It may require the enlistment of professional support. It may call for raising money either by public appropriations or by contributions from individuals and foundations. Education is often necessary before these steps can be taken.

The Audience—Every phase of strategy calls for the participation of people, sometimes singly, sometimes in groups. From step to step, they may be very different people—general citizens, teachers, clergymen, doctors, and others. This means that all the people who need to be moved to think, feel, and act in a certain way in favor of the program cannot be identified by any rule of thumb. For each phase of the program they are different and differently timed. For some goals the major effort may be focused on a broad citizenry, or on the parents of babies or of school children, or professional bodies or leaders, or executive authorities such as governors. However, if the strategy is well laid out, the strategic people will soon become evident. One cannot, as a rule, simply pour a wealth of mental-health education into these strategic people and then hope that they will turn their efforts in the direction that will be in line with the goal. The education must be tailor-made, and it must make clear what these people can do. Further, two people or groups may be expected to perform similar rôles, but the backgrounds of the two may be so different as to require very different motivation. For some, other forms of motivation than education may be needed.

I stress this because of the importance of tuning the educational effort to other motivational efforts, such as lobbying.

The Message—This is the heart of education. What should education deal with? What funds of knowledge have we to choose from? How definite is that knowledge? Since this is the heart of the task, I am going to return to it after a few words about the channels.

The Channels—The media of education are sometimes simple, sometimes quite technical. People talk with one another in everyday, informal ways, but there is an organized body of knowledge about such media as addresses and lectures, films, stage plays, radio, television, news reports, and other channels. There are also specialists who should be called upon to advise on the use of these channels, so that valuable resources will not be wasted in the educational effort.

And now back to the message. In this particular program of WNYC, the goal is well-defined. The effort is to do something important to help people to grow up steadily and healthfully, so that they can be (1) at ease with themselves; (2) helpful to and capable of being helped by other people with whom they may be in touch; and (3) capable of dealing with the conditions of life realistically and constructively. That, in a nutshell, is maturity.

The first of these signs of maturity, being at ease with oneself, is the key to the second and the third, for the attitude that one has toward oneself determines very much how one will react to other people and to life's conditions. For example, a person who is continuously suspicious of others, who sees an enemy, perhaps a communist, lurking behind every acquaintance who differs with himself, is a person who is very unsure of himself. He will be apt to try to control the world about him in such a way that it will be least threatening.

The task of education for sound emotional development toward maturity is, then, essentially one of building up one's ability to feel appropriately comfortable about oneself. This does not call for perfection. The person who has achieved maturity is neither overdemanding of himself nor complacent about his shortcomings to the point of ignoring the possibilities of improvement.

How is this goal of maturity to be reached? How do people advance their maturity and what blocks them? Are there any particular stages in their life when they are most apt to be blocked? Progress toward maturity comes in part from the effects of the world about us, our environment, and in part from the conditions that exist within us, our constitutions. More and more evidence is coming to the fore to show that it is impossible to separate these internal or constitutional and external or environmental forces, they are so closely intertwined. Constitutional and environmental forces play upon each other to the point where it is often hard to distinguish which is which. One's bodily make-up begins at birth to be shaped by the world about one and in very subtle ways. The regulation of bowel and bladder functions, the schedule of eating, the use of certain muscles more than others —all of these make for structural changes that in turn influence one's behavior.

At the same time each person tries to shape the world about him in accordance with his bodily needs. The structure and equipment of his home are influenced in that way. When the body suffers, the whole routine of life may be changed and lasting psychological changes may result. Much has been written lately about the damage that may be done to a child by careless separation of the child from the parents in time of illness. Many hospitals have come to realize that children who come in as patients are especially sensitive, and as a result many hospitals have changed their visiting rules in order that the child may be assured of a continuing relation with his parents.

But this change of rules involves the education of a good many people, not only to get the rules changed, but to have them carried out in the spirit that was intended. The child who is physically or mentally handicapped is especially vulnerable, and the wise doctor, nurse, teacher, or parent needs to be strengthened through education to deal with the whole child as well as with his handicap.

Development progresses rapidly in the earlier years. Some cultural anthropologists have indicated that the ways of life that are characteristic of different peoples and different nationalities become fairly well fixed before the age of five—in

some countries as early as six months. If a child is switched off on a wrong cultural track for any length of time, a great deal of effort may have to be expended in order to undo this deviation, and the return may be only partial and leave a residue as a permanent problem. Therefore, most crucial in the development of a child toward maturity are those people who bring influences to bear upon him in his earliest years. These are the main audience for education for mental health. They are the parents, the public-health nurse, the physician, and the clergyman in particular. Coming along later, after many attitudes and habits have become fairly fixed and after a good deal of good or bad development has taken place, is the teacher; and still later come those with whom one works and plays in the home, in the neighborhood, and in industry. The rôle of each of these is different. Each is in a position to do more than he is now doing. Each has limitations that have to be taken into account. For eample, with the parent both affection and anxiety have to be considered in an educational program because they involve both positive values and risks.

There is a rapidly growing body of scientific knowledge that can be used in an educational program with all of these groups. Too much stress cannot be laid upon the importance of maintaining a family atmosphere that permits the child to progress toward more and more dependence upon himself. You may note that I said permits rather than helps because the child has the possibilities of growth within him if given a chance to move steadily toward greater maturity. The danger lies in his retreating into immaturity as a result of being hurt, or of taking a side track that leaves him at odds with others. Some of this side-tracking may occur as early as the first two weeks, when the nurse rather than the mother becomes the source of the child's food and close personal, comfortable relationship.

Many years ago Margaret Ribble wrote a book called, *The Rights of Infants,* in which the damage to children as a result of awkward separation from the mother was high-lighted. This possibility of damaging children was carried further by René Spitz who showed how seriously children can regress if hospitalized and cut off from their parents. The World

Health Organization took this problem so seriously that it delegated Dr. John Bowlby to make an international study of the emotional development of children. His book, *Maternal Care and Mental Health,* has already become a classic.

Handicapped children are often dealt with in ways that give full consideration to the handicap, but little to the child. Children who are underweight, and particularly those with a tuberculous parent, are often taken away from the home for as much as a six-months period for upbuilding. Often they are taken so far away from home that they lose contact with the parents completely.

Cultural anthropologists have shown us how the handling of young children prepares them for the customs and attitudes of the folk to which their families belong. But it is quite clear from the anthropologists' work that the attitude of the parents and the kind of rearing that helps the child to mature in one country may be quite the reverse of what is needed for his adjustment in another. For a community with as varied national backgrounds as New York, it is obvious that special safeguards need to be developed to protect children from the hazards of conflicting customs, especially when the parents themselves are emotionally overwhelmed by the customs of this country that are new to them.

It has long been recognized that children from broken homes face a special hazard. Many children struggle to find a comfortable solution to these confusions of their growing-up period. They may find it in deviant behavior such as delinquency. Other children, by sheer luck or outside help, find a happier solution. But the chances for an unhappy outcome can be reduced by education that helps parents, doctors, teachers, social workers, and courts to do a better job.

From what I have said it sounds as if the only way that one could carry on a program of mental-health education would be to beam the message to every parent, and this is more or less the case. But it is so large a task that we cannot hope that it will be beamed from one point. All of those who deal with families, especially when the child is young, but also when he is in school, are in a position to be messengers. Health, education, and welfare agencies, clergymen, and courts are strategically situated both to learn and to teach, but they

have a rôle to play that is even more basic than being messengers to the parents, for they are often in a position to influence the conditions under which families live and in which children grow up. Still, at best the results of their efforts to influence the child's progress toward maturity in his early years will be imperfect.

For that reason the schools stand in an especially strategic position. They are in a position to buffer some of the adverse influences that bear upon the child. They are in a position to provide a good atmosphere within the school that can counterbalance the reverse at home and in the neighborhood. The least that one can expect of a school is that it should not hurt the child further, and to this end that it should take into account that children differ and need different kinds of help from the school.

All of this calls for the education of school boards and school administrators. It calls for the education of teachers' colleges and the public that supports them. It calls for an understanding of the importance of selecting teachers so that the child may live in an atmosphere in which the teacher is encouraging rather than discouraging to his development toward maturity.

Education for mental health, it is obvious, is a tremendous task. It is not a task that can be shoved off on any one person or group. It is everybody's business.

SOLVING THE PROBLEMS OF EMOTIONAL ILLNESS*

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IT has been estimated that nearly one million people are treated in mental hospitals throughout the country each year, and that many times that number are suffering serious neuroses or personality disorders—perhaps as many as 6 per cent of the population. Nearly two million serious crimes are committed each year in the United States, and one and a half million youths between the ages of seven and seventeen are arrested annually. There may be as many as four million problem drinkers and nearly one million chronic alcoholics.

Great as the magnitude of the problem is, it assumes even larger proportions when it is realized that as we learn more, the problem of emotional disorder encompasses more. The borders may, like the horizon, be truly infinite. Not too many years ago in an historical sense, even psychoses were not considered illnesses, and certainly their treatment was not within the province of medicine. Traditionally, those who are ill turn to the medical profession for help, and when it was accepted that psychoses and psychoneuroses were illnesses, their treatment became a responsibility of the physician. The physician may have contributed, but he is not responsible for bringing about this change. In the end it is society that determines what is illness and what is not.

For many reasons, the medical profession was slow in turning its attention to the problem of emotional illnesses. For one thing, it didn't understand them, it didn't know what caused them, and it didn't know how to treat them. The doctor was little better off than the layman, and he shared the misconceptions and the prejudices and attitudes of society in

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general. Nor were the schools of medicine of much help. One great discovery after another in the fields of bacteriology and immunology, pathology, physiology, and pharmacology gave great impetus and encouragement to study and research in these areas and their emphasis in the medical curriculum. It was hoped that eventually the answer to all disease would be found by diligent, continued work in discovering more organisms, or more chemicals or enzymes or hormones or operations.

Perhaps it is because such tremendous strides were made through this organic approach, and because so many of the threats to physical health have been eliminated by truly wonderful advances in surgery and in the control of infectious diseases, that more attention can now be turned to disorders of emotional origin; and it seems quite clear that the medical profession is now becoming more interested in psychological medicine. The physiologist is turning his attention more and more to the nervous system and the internist is more willing to consider the possibility that emotions may be playing a significant rôle in disease processes. Meanwhile the borders of psychiatry extend further. Just as psychoses were once considered social disorders and later medical illnesses, so we are now seeing attitudes toward other social disorders changing. Less bizarre behavioral abnormalities, like excessive drinking, delinquency, crime, and difficulty in getting along with others, are more and more being considered illness, and primarily by the public.

We have come to recognize that the human organism is not only struggling to resist invasion by infectious agents that are ever present, and to maintain a metabolic balance, but that it is constantly struggling against the restrictions and requirements that a civilized culture places in the way of free expression of emotions and impulses. This struggle goes on just as much outside of awareness as does the one against infection. Furthermore, we know that a person who is overwhelmed by a physical force like infection is less capable of coping with psychological stress, and we can postulate that the person who is overwhelmed by psychological forces may be less capable of coping with physical stress.

Psychoanalysis has given us a research tool that has per-

mitted us to learn much about this internal struggle that goes on between the wishes and impulses born of instincts and the demands of reality and of our ideals. We have gained some insight into the mechanism by which emotional equilibrium is maintained and some inklings into why sometimes it is not. We have learned about the devious ways emotional conflict may express itself, and have seen how it may result in organic disease, be it an ulcer or a broken leg. This has widened the horizons of psychiatry still further and added to a load that was already too much for the medical profession, as presently constituted, to cope with adequately.

Even to-day there are still some state hospitals without a single trained psychiatrist on their staffs and the average state hospital is still a huge custodial center instead of a treatment center. Thousands of mentally ill people who might be benefited by early treatment are not receiving it because of serious shortages of staff and equipment. Many people who need hospital treatment are not even getting to the hospitals. In several states mentally ill people spend months in jail waiting to be admitted to a hospital. In our better hospitals, each doctor may have 200 or more patients to treat, our clinics have long waiting lists, and we have only scratched the surface of the great mass of psychosocial problems that are being increasingly recognized as medical problems.

Even now, with so many of our trained psychiatrists turning away from the treatment of the sickest patients, the psychotics, in their private practice, and with some clinics doing the same, we would not be able to have any kind of treatment program for our hospitalized and clinic patients were it not for the immeasurable amount of help we are getting from nurses, psychologists, social workers, attendants, occupational and physical therapists, recreational and educational workers, and volunteers. It is a sad fact that these members of the psychiatric team often have a greater understanding of the problems of emotional illness than many of our doctors in whose hands the responsibility for the treatment of these patients still rests.

The average medical graduate, even after internship and residency, does not know how to treat the patient with an emotional disorder. He has not been trained to do so, even though it has been repeatedly estimated that approximately

one-half of all the patients who visit doctors' offices do so because of emotional rather than organic troubles. The medical graduate knows about the treatment of heart disease and diabetes and measles, but he doesn't know the principles of psychotherapy. Nor is it going to be easy to change this. For a long time the physical and biological sciences have been stressed as prerequisites for medical training, but not psychology and the social sciences, which are the basic disciplines upon which modern psychiatry rests.

Competition for time in the medical curriculum is keen, especially with knowledge increasing each year in all the specialty areas. Certainly much more is being done now than twenty years ago in the teaching of psychiatry, but it is being done in the face of serious doubts, expressed and unexpressed, on the part of medical colleagues who feel that we may be trying to do too much. There are many who recognize the universality of emotional disorders and who are convinced of the need to train all doctors to treat the early and less serious case, but there are still many who are content to have "psyche" and "soma" considered separately and to delegate the treatment of patients unfortunate enough not to have any organic disease to the psychiatrist if they insist on help.

We are occasionally asked if we are trying to make psychiatrists of all medical students when we insist that we don't have time to teach them what they need in order to treat scientifically one-half of the patients they will see. We are not trying to train them to be psychiatrists; we are trying to train them to be *doctors.* The concept that a doctor needs to know how to treat the functional case as well as the organic case still needs to be emphasized; and this is a radical departure from medical traditions of the recent past.

The importance of treating a syphilitic infection very early is well accepted. Generally it isn't because the patient is actively or seriously ill at the time, but because we are all too familiar with what will happen many years later if the patient is not treated. We do not take nearly as seriously the first-stage symptoms of an emotional disorder which later on can develop into a chronic psychosis, or antisocial behavior, or a seriously disturbed patient who passes his or her neuroticism on to future generations.

Why is this the case? Is it because of some need to deny

emotional turmoil in others because of the need to deny it in ourselves? Is it because the problem is so great that our impotence to deal with it makes us turn away from it? Is it a manifestation of the natural resistance to change, or being more comfortable with the familiar? It is probably all of these, but there is more.

Our therapeutic results and even our theories, techniques, and principles are questioned by our colleagues and by the public. They tolerate the teaching of psychiatry and some even encourage it, but with serious inner doubts. We are criticized for the length and excessive cost of our treatments. It would be a mistake to dismiss these doubts and criticisms as "resistance." To a considerable degree they are justified, and to the extent that they are justified, we have failed.

Each and every psychiatrist can point to the many patients he has helped, but to what extent can he predict and even reproduce the same results in others? To what extent has he used control cases and validated in a scientific way the effectiveness of his treatment? What do we really know about the prevention of emotional illness? Have we ever adequately demonstrated that we have achieved any prevention? Can we demonstrate it statistically or by incidence figures?

These are the proofs that are demanded of us. We don't even have any reliable incidence figures, still less evidence that they have changed. The average person would probably say that there is more emotional illness now than ever before despite all of our mental-hygiene programs. Others feel that the incidence has not changed, but that more of what always existed is being admitted and in turn reflected in an increased demand for help. There are those who say that delinquency, for example, has not really increased, but that society has broadened its definition of delinquency; that what was within normal limits twenty-five or fifty years ago is to-day considered delinquent. We have hardly agreed on such fundamentals as what constitutes emotional illness. The concept of it changes from generation to generation. How much unhappiness or malfunction or "acting out" can be considered healthy or normal? It seems that emotional illness is like the common cold—something that we all have at one time or another with different frequencies and different severities.

While there is some basis for the dissatisfaction about the great length and excessive cost of psychiatric treatment, all of the criticism is not justified. It should be remembered that the treatment of other chronic diseases, such as tuberculosis or arthritis or cirrhosis of the liver, may be prolonged and expensive.

Furthermore, perhaps the comparison of psychiatric treatment with some of the more circumscribed and dramatic medical and surgical treatments is not fair. Psychiatric treatment at present is of a different order. Ideally it is essentially a process of reëducation for living. How many individuals who have everything to live for are unhappy and maladjusted because of attitudes and fears that were established in childhood and never resolved or corrected? When one considers that four full years are spent in college, not to mention all the schooling before that, in preparation for life on the intellectual side, it does not seem so unreasonable to spend half as much time getting educated emotionally.

Doctors in general consider it a disgrace to miss an organic lesion, but somehow do not seem to mind so much missing a functional disorder. Often this will be justified by the attitude, "You can do something for the patient with an organic disease, but little or nothing can be done for the patient with an emotional disorder." Sometimes one hears the mistaken notion that people don't die from psychiatric illnesses. Actually much more can be done in the treatment of the psychoses or psychoneuroses than can be done to cure multiple sclerosis, polio, and many types of heart disease. Some years ago an English physician said, "It is better to attribute incorrectly a small percentage of organic illnesses to functional causes than to condemn a large number of healthy patients to the fear of non-existent disease."

We are told that this is carrying things too far, but is it any worse than the alternative? We are still able to ignore too easily the fact that approximately one-third of the five million men rejected for military service were turned down for neuropsychiatric reasons, and that psychoneurotic disorders were the most common cause of loss of man power from the services. We can maintain more equanimity in the face of epidemics of delinquency, chronic alcoholism, and

crime than we can in the face of an epidemic of polio. It is the traditional approach of medicine more than anything else that perpetuates the emphasis on the organic and the neglect of the emotional. It is this attitude that needs to be changed.

What can be done to help bring about the change? Of no small importance will be public insistence upon it. Through public educational programs some change has already come about. More and more patients are expecting their physicians to be interested in them as people rather than as a conglomeration of organs, and the physician who continues to ignore the psychological side of medicine will be like the one who hasn't learned about antibiotics.

Whether a psychiatric unit of a medical school is built as an integral part of the school or constructed half a mile away, is a matter that is very much a concern of the public. If the stigma connected with mental illness is to be eradicated, if the treatment of mental illness is to be given early and arranged with the least amount of legal red tape and procedure, and if patients with mental illness are to be given the same consideration as those who have broken down in a different way, it is essential that psychiatric facilities be provided right along with medical and surgical facilities.

If the treatment of the psychiatric patient is to be considered a part of medical practice and if medical students are to be given training in the principles of such treatment, complete integration of psychiatry with other phases of medicine is essential. Unless there is public demand for it, the chances are it will not be provided. Former Governor Dever, of Massachusetts, in a recent talk to the members of the Group for the Advancement of Psychiatry, emphasized the importance of public groups' making their wishes known to the state administrations. He commented on the reluctance of mental-hygiene groups to press their demands as vigorously as other groups with less vital interests.

Whatever progress has been made in the treatment of the mentally ill in the past twenty-five years has been made possible by outbursts of public indignation and public demands for improvement of conditions in the state hospitals. We can look with great satisfaction on the increased rate of recovery and improvement that has stemmed from enlightened pro-

grams. For example, in the New York State mental hospitals the rate of recovery and improvement for schizophrenic patients has increased from 30 per cent to about 55 per cent. In seven other states the proportion of schizophrenic patients discharged from the hospital within twelve months after admission is now 56 per cent as compared to 33 per cent in 1914. The National Institute of Mental Health figures show that for seven states 70 per cent of patients with involutional melancholia are out of the hospital within a year, as compared to 35 per cent a few decades ago.[1] In the Biennial Report of the State of California Department of Mental Hygiene for 1950–1952, it is pointed out that for every 100 patients who receive treatment in California state psychiatric hospitals, more that 75 are turned back to normal lives.[2]

If so much can be accomplished under conditions that are so far from being adequate, how much more could be done if the hospitals were given the personnel and equipment they need? The Stockton Pilot Study[3] showed this all too clearly. The demand for improvement of the care of the mentally ill must be unremitting, and since many of the state hospitals have abandoned their farm programs, there is no valid reason for continuing to build state hospitals in isolated areas where

[1] National Association for Mental Health, Inc., Third Annual Report, 1952–1953.

[2] This statement is found on page 5 of the report. Further on (page 46) the matter is taken up in somewhat more detail. The report points out that a study that was completed in February, 1951, showed that the number of therapeutic releases had increased to a new all-time high, both in actual numbers and in proportion to admissions. By "therapeutic releases" is meant the number of people who are returned to society, either by direct discharge or by successful leave of absence. In 1951, for every 100 people admitted, 76 were released. Those released were not necessarily the same ones who were admitted. The report goes on to say ". . . but since mental illness yields most readily to immediate treatment, when it yields at all, the use of the admission rate as a statistical base was considered more valid. Although 76 patients were released for every 100 admitted in 1951, it should be pointed out that the chances of a mentally ill patient getting well in California are not necessarily 76%."

A later study completed in March, 1952, measured the cumulative rate of releases (net leave, direct discharge, and discharge from short visits) for four diagnostic groups within five and one-half months: roughly 15 per cent of the patients in cerebral-arteriosclerotic and senile groups, 42 per cent of the schizophrenia patients, and 86 per cent of the non-psychiatric alcoholics had been so released.

[3] See "Intensive Treatment of Back-Ward Patients," by E. F. Galioni, F. H. Adams, and F. F. Tallman. *American Journal of Psychiatry*, Vol. 109, pp. 576–83, February, 1953.

problems of personnel recruitment are multiplied many times. We must do what we can to discourage the building of state hospitals in remote areas. Their continued isolation symbolizes the wish to get the psychotic patient out of sight and out of the way. The public needs to face the problem and not deny it, if for no other reason than the economic. How many people know that over one-half of all the hospital beds in the country are for psychotic patients?

Our psychiatric hospitals desperately need all types of personnel. The standards established by the American Psychiatric Association are geared to minimum acceptable care and are very much a compromise with the practical realities of to-day. They are not ideal nor adequate for the kind of treatment program each and every one of us would want for those who are close to us if they were in need of help. Yet the Illinois Society for Mental Hygiene reports that not one of the public mental hospitals in Illinois meets the minimum personnel standards of the A.P.A. When state hospitals really become treatment and research centers, they won't go begging for psychiatrists who now, for the most part, actively avoid taking positions in them. First priority must be given to the development of training facilities for all types of personnel making up the psychiatric team.

But we need to look even further than the state hospitals that stand out as dark spots in an enlightened civilization. There are the almost numberless patients who are not ill enough to require hospitalization who need help. The further development of group-treatment methods offers the only hope until preventive methods are more effective.

We cannot undo neurotic behavior in parents by prescription, but we should aim toward helping parents understand how their neurotic problems affect their children and offer such parents some help for themselves through group work if individual treatment is not possible or available. This can truly be preventive psychiatry and should be an integral part of any public-health program.

Early signs of emotional disorder or maladjustment should be sought in the preschool and school child just as carefully as physical disorders are looked for in routine check-ups. Teachers and ministers, as well as parents and workers in

mental health, must be given an understanding of the principles of mental health and a familiarity with the early signs of emotional illness so that they may be better prepared to deal with the problems that are so often presented to them. Why could there not be a television program that each week would present the life history of a mentally ill patient, showing the forces that have contributed to his breakdown and demonstrating that mental illness is not something that comes "out of the blue"?

We must work toward an extension of the dynamic therapeutic approach in our prison and correction systems. The work being done now at the Terminal Island Facility[1] is an excellent example of what can be done with group therapy and parole that makes output treatment obligatory. We need to encourage the routine construction of psychiatric units in general hospitals, so that patients with emotional illness can be treated as others are. There is the continuing problem of the senile patient and the urgent need for research in practically all aspects of emotional illness.

In order that psychiatry may become really integrated with the practice of medicine, we must establish incidence base lines; define the epidemiology of emotional disease; define the rôle of social factors in producing mental illness; learn more about why certain persons succumb; establish more definitely than we have done so far the factors that contribute in a positive way to mental health; demonstrate the effectiveness of therapy by careful experimental design and the use of controls and the effectiveness of preventive programs through long-term studies. We must continue to search for briefer and less costly methods of treatment, and always bear in mind that we are just at the threshold of psychological medicine with a truly long way to go. Finally, we need funds that will permit us to attract trained people into research, so that they can devote themselves to these urgent unanswered questions.

[1] A State of California Department of Corrections institution at San Pedro, California, to which selected men are sent for rehablitation from prisons throughout the state.

SUBSEQUENT MILITARY PERFORMANCE OF SOLDIERS TREATED AT A MENTAL-HYGIENE CONSULTATION SERVICE

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DURING the first years of World War II, it became apparent that emotionally ill or maladjusted soldiers might best be evaluated and treated during the period of basic training. A review of the entire psychiatric experience of World War II, made at the end of the war, indicated that intensive psychiatric screening at induction stations was impracticable, and that hospitalization of emotionally ill or maladjusted soldiers was very expensive in money and time, and often aggravated the basic disorder. Early evaluation and treatment or separation of possible psychiatric casualties was clearly sound mental-hygiene practice, in terms of prevention of later ineffectual performance or disability.

In 1943, the first mental-hygiene units had been established in basic training centers, to deal with the prevention of mental disorder and with problems of emotional maladjustment, classification and reclassification, disposition, and screening, Such units were usually established in close association with the troops, apart from hospital facilities. Case contacts were maintained on an ambulatory outpatient basis. The intention of such units was to assist those individuals whose maladjustments were correctable to adjust to army service; and to eliminate during the early weeks of training those individuals who, because of mental or emotional instability, were or might

become a liability to military efficiency, discipline, or morale. It appeared obvious that proper utilization of such services would aid materially in salvage of man power, reduction in hospital admissions, and improvement of the mental health of the command.

In February, 1952, a mental-hygiene consultation service was established at Fort Bliss, Texas, to deal with emotional problems of trainees in the Anti-Aircraft Artillery Replacement Training Center. Preventive-mental-hygiene and clinical-psychiatry programs were organized. Any soldier whose behavior in any way presented a problem—to cadre or administrative or command officers, to unit medical officers, or in his own personal adjustment—that could not be solved at battery or dispensary or individual level, was considered to be a subject for reference to this service. Soldiers might thus be referred by any member of the training-center organizations, including the soldier himself. The majority of cases were referred by unit dispensaries, but many came from unit commanders, staff and special-section officers, chaplains, legal officers, and others.

After social-case-work study, psychological examination when indicated, and psychiatric evaluation and treatment, each patient was recommended for one of four basic dispositions: (1) full duty with no limitations; (2) modified duty, with possible reclassification or reassignment to a different job or unit; (3) hospitalization; or (4) separation from the military service under the provisions of various army regulations for medical or administrative discharge.

During the early months of the existence of the mental-hygiene consultation service at Fort Bliss, line and command officers were sceptical of our statements: that effective performance as a soldier depends a great deal on a man's emotional stability and maturity; and that the consultation-service personnel were qualified to evaluate a given individual to determine whether he was emotionally qualified for his present duty, and, further, to prognosticate as to his capacity to stand up under the stresses his particular assignment might provide. Command officers had noted that approximately half of the patients studied and treated at the Fort Bliss mental-hygiene consultation service, and at mental-hygiene services at various

posts throughout the country, were recommended for return to full duty. As the command officers were familiar with the high discharge rate of patients with neuropsychiatric disorders during World War II, and as only about 4 per cent of the total number of trainees processed at this post were referred to the consultation service at any time during their basic training, it was felt that the service might be returning to duty individuals who would soon again demonstrate maladjustment or ineffective performance as soldiers.

Plan of the Study.—In order to evaluate the subsequent duty performance of soldiers treated at the consultation service, in early 1952 a follow-up study was initiated by the Military Personnel Division, Adjutant General Section, Headquarters, Anti-Aircraft Artillery and Guided Missile Center, Fort Bliss, Texas.[1] Headquarters officers desired to test one hypothesis and one hypothesis only: whether individuals studied and treated at the mental-hygiene consultation service, and, after completion of study and treatment, recommended for return to full duty, would then perform effectively as soldiers of the line. The individual soldier was to be evaluated solely by line officers, and solely on the basis of his subsequent performance as a soldier in his assigned duty. Medical and mental-hygiene personnel were to have no part in the immediate evaluation of the individual soldier, once his case had been "closed" at the mental-hygiene consultation service. Individuals recommended for reassignment, reclassification, or any other modification of duty were not included in the "subject" group; headquarters personnel considered reclassification or modification of duty as a continuing form of "treatment," and men so recommended were considered to be "under treatment" as long as their duties were modified.

Standard rating forms were then devised and sent, at the first of every month, to the unit commander of each patient who had been studied, treated, and returned to full duty. The unit commander was not informed of the purpose of the rating. He was simply requested to rate the soldier's performance as satisfactory or unsatisfactory; to list in a separate section any commendable or derogatory personnel actions relating

[1] The data for this study were collected under the direction of Lieutenant Colonel John F. Muldoon, A. G. C., A. V. S.

to the soldier; and to include any pertinent general remarks about the soldier's performance. The criterion of performance was, therefore, based entirely upon the functioning of the individual soldier in his military assignment, as judged by his unit commander.

The original plan was that the performance of every patient studied and treated at the mental-hygiene consultation service, and returned to full duty, during the six-months period from February through July, 1952, would be rated two months after his case had been "closed" at the consultation service, and then rated every month for six months. Actually, because of their impression that the data already gathered were consistent and satisfactory, the Adjutant General Section discontinued distribution of rating forms in September, 1952. Therefore, no soldier received more than four successive monthly ratings. The first rating in each case was made two months after the subject's treatment was terminated at the mental-hygiene consultation service, and the majority of subjects were then rated for two or three successive months.

Results of the Study.—During the period February through July, 1952, 434 patients were seen at the mental-hygiene consultation service.[1] Of these 434 patients, 14 per cent were hospitalized; 17 per cent were recommended for reassignment, reclassification, or modification of duty; 22 per cent were recommended for separation from the service; and 47 per cent (204 cases) were recommended for return to full duty. It was these 204 cases that were evaluated in the follow-up study.[2]

Table I lists the recommended disposition of the total 434 patients, classified by diagnostic category. It should be noted that of this total number of patients almost one-third were diagnosed as immaturity-reaction types, over one-quarter as psychoneurotic, and almost one-sixth as pathological-personality types.[3] Those patients recommended for return to full

[1] This number does not include nine patients diagnosed as suffering from organic neurological disorders.

[2] A similar study of the subsequent military performance of those patients examined and treated at the mental-hygiene consultation service and recommended for reassignment, reclassification, or modification of duty, is now in progress.

[3] Diagnostic categories were formulated according to the Joint Armed Forces Psychiatric Nomenclature (1949).

TABLE I. RECOMMENDED DISPOSITION OF 434 PATIENTS STUDIED AND TREATED AT THE MENTAL-HYGIENE CONSULTATION SERVICE, FORT BLISS, TEXAS, FROM FEBRUARY THROUGH JULY, 1952

Diagnostic category	*Total number*	*Full duty*	*Reassignment, reclassification, or modification of duty*	*Hospitalization*	*Separation from military service*
Immaturity reaction ..	141	85	27	3	26
Psychoneurotic disorder	112	45	20	26	21
Pathological-personality type	62	33	7	0	22
Psychotic disorder ...	37	0	0	28	9
Transient personality disorder	31	15	14	2	0
No psychiatric disorder	25	22	3	0	0
Mental deficiency	16	4	2	2	8
Addiction	10	0	0	0	10
Total	434	204	73	61	96

TABLE II. SUBSEQUENT MILITARY EFFICIENCY OF 204 PATIENTS RETURNED TO FULL DUTY AFTER STUDY AND TREATMENT AT THE MENTAL-HYGIENE CONSULTATION SERVICE, FORT BLISS, TEXAS

		Rated by unit commanders		*Not rated by unit commanders*		*Total number who performed effectively in their military duties*
Diagnostic category	*Total number of patients*	Total number of patients	Number who performed with satisfactory efficiency	Total number of patients	Number who completed course of training	
Immaturity reaction	85	45	40	40	38	78
Psychoneurotic disorder	45	27	25	18	18	43
Pathological-personality type	33	21	10	12	12	22
No psychiatric disorder	22	14	14	8	8	22
Transient personality disorder	15	9	8	6	6	14
Mental deficiency	4	3	3	1	1	4
Total	204	119	100	85	83	183
Column index	A	B	C	D	E	F

duty included two-fifths to three-fifths of all patients in each of the diagnostic categories, "immaturity reaction," "psychoneurotic disorder," "pathological-personality reaction," and "transient personality disorder."

Table II lists the performance ratings of those patients returned to full duty in each diagnostic category. Column D of the table shows the number of individuals in each diagnostic category who were not rated because they were transferred from Fort Bliss during the two-months period between the termination of study and treatment at the mental-hygiene consultation service and the first evaluation rating. However, 83 of the total of 85 cases who were not rated had successfully completed their course of training and qualified for transfer to a permanent unit. It was the opinion of headquarters officers that a man able to complete his course of training successfully must be considered (from the army point of view) to have performed with satisfactory efficiency. These 83 individuals are, therefore, listed in Column E and included in the final listing in Column F of those whose performance was successful. The two individuals who were not rated and who did *not* complete training are included with those whose performance of duty was considered to be unsatisfactory.

There was some question as to how the total monthly ratings for each man should be consolidated. It was suggested that only the "final" rating—*i.e.*, the *last* monthly rating—be used, because conceivably a soldier might show poor performance shortly after termination of treatment, but later improve. On the other hand, a *single* rating for any one month might be of little practical significance, as it might well vary with the particular personalities and interpersonal relationships of the rating officer and the trainee in that particular month. Another possibility was to consider whether the *predominance* of all ratings received by any one subject was satisfactory or unsatisfactory. Finally, the *trend* of the ratings might be considered. However, on comparison of tables made using each of these four criteria of total performance, it was found that there was less than 2 per cent variation in either direction in the final totals, and less than 5 per cent variation in either direction in any single diagnostic category, no matter which of the four criteria of total performance was used.

In Column F of Table II are listed, then, the total number of men in each diagnostic category whose continued military performance was considered by line and command officers to be satisfactory. It will be seen that of the 119 cases who were rated, the performance of 100 (84 per cent) was considered to be satisfactory, and of the 85 cases who were not rated, 83 completed training and their performance was also considered to be satisfactory. Of the total number—204 cases—who were studied and treated at the mental-hygiene consultation service and recommended for return to full duty, during the six-months period from February through July, 1952, 183 (90 per cent) were considered by line officers to have adjusted to military life and to have performed effectively as soldiers in full military duty.[1]

It should be noted that these high levels of satisfactory performance by treated patients did not hold true in one diagnostic category—the pathological-personality type. In this category (including the schizoid, paranoid, cyclothymic, inadequate, antisocial, amoral personalities, and the sexual deviates) less than one-half of those rated, and only two-thirds of the total category, performed in a manner that was evaluated as "satisfactory." This was true although little more than half of the original number of patients diagnosed in this category were returned to full duty.

These results indicate that a large majority of men studied and treated at a mental-hygiene consultation service, and recommended for return to full duty, are able to adjust and perform effectively in their military assignment. The objection raised to most follow-up studies—that criteria of "adjustment" are vague or prejudiced—cannot be raised here. Evaluations were made entirely by line officers who were unaware of the purpose of the evaluation, and the single criterion of "adjustment" was the soldier's ability to perform effectively in his *military* duties.

Another objection might be made—that in the period during which this study was performed, the personnel of the mental-hygiene consultation service might have selected for return

[1] This figure is statistically significant, as it would occur by chance less than one in 1,000 times.

to full duty only those patients for whom the chance of subsequent satisfactory performance appeared to be extremely high. This objection is not supported by the facts. First, the follow-up study was not initiated, nor even planned, until the service had been in operation for two months. Second, disposition figures for the six months after the study had been discontinued (August, 1952, to January, 1953) showed a percentage returned to full duty only slightly higher than that during the original six-months period of the study, despite a marked increase in the total number of patients referred to the consultation service. Third, the percentage of patients recommended for return to full duty from Fort Bliss during the period of the study was very close to the mean percentage so recommended in all mental-hygiene services in the country.

The 434 cases seen at the mental-hygiene consultation service during the six-months period of the study included all patients with any type of psychiatric disorder who might, had there been no mental-hygiene service, have been hospitalized and perhaps later discharged as psychiatric casualties. (No Fort Bliss trainee was hospitalized for psychiatric disorder unless he was first evaluated at the consultation service.) As almost half of this total number of patients were returned to full duty and proved to be effective soldiers, and as another sixth were recommended for modified training or reassignment (some of whom, at least, proved effective and of value to the army) salvage of man power by the mental-hygiene consultation service was apparently quite high. From the point of view of the army, this is extremely important. The basic mission of the army medical service is "to conserve the fighting strength" and these figures would indicate that mental-hygiene consultation services contribute their part.

These generally good results were obtained without extensive therapeutic regimens. With the large case load and limited time and personnel, only about 6 per cent of the total number of patients seen during this period were accepted for therapy extensive enough to involve more than seven interviews. Ninety-four per cent of the cases were studied and treated in six visits or less. The median number of visits was approximately three, being somewhat higher for patients diag-

nosed as suffering from psychoneurosis or character disorder, and lower for patients diagnosed as suffering from transient personality disorder, mental defect, or no psychiatric disorder.

To summarize, the first follow-up study of patients treated at an army mental-hygiene consultation service was accomplished when non-medical military personnel evaluated duty performance of patients examined and treated at the mental-hygiene consultation service, Fort Bliss, Texas, during the six-months period from February through July, 1952. All patients recommended for return to full duty by the psychiatric staff were evaluated by line officers, through an organized method of reporting initiated by command officers, on the basis of efficiency in performance of duty as a soldier.

Results indicated that almost half of the patients studied and treated at the mental-hygiene consultation service were returned to full duty, and of these, 90 per cent were considered to perform effectively in their military assignments. This figure was statistically significant and was consistent in all diagnostic categories except for patients diagnosed as "pathological-personality types"; of these only two-thirds of the group returned to full duty performed effectively. This appears to indicate that (exclusive of psychotics and addicts, none of whom were returned to full duty) the pathological-personality types are the poorest adjustment risks in military service.

The study also indicates that skilled personnel can determine with a high degree of validity a patient's intellectual and emotional capacities to perform effectively in military duty; that these prognostic and therapeutic results may be obtained in a military situation with psychiatric procedures that are intensive and thorough, but limited as to time and goal; and that mental-hygiene consultation services play a significant rôle in the conservation of army man power.

COMMUNITY ACTION AND MENTAL-HEALTH PROBLEMS OF CHILDREN*

HERSCHEL ALT

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AS I understand our assignment, it is to consider what we can do to help emotionally disturbed children. We ask ourselves, What are some of the steps that might be taken by individuals, groups, and the organized community to prevent the occurrence of mental and emotional disturbances in children? What is back of these phenomena? How could they have been prevented? What can be done to find the children who are already showing difficulties, and to bring help to them as early as possible? How can we make sure that children in need of treatment will receive it?

As we ask these questions, we see many manifestations of psychological difficulty among us. There continues to be widespread discussion of the rise in delinquency, of the increase in admissions to state hospitals, of long waiting lists for the services of social agencies and mental-health clinics.

Thus, a recent study found that 10 per cent of the children in schools throughout the country were considered sufficiently disturbed to be in need of specialized help. The central registry maintained by the New York City Youth Board receives reports from all official and voluntary agencies on children and young people between the ages of five and twenty known to be delinquent or emotionally disturbed. This registry shows that approximately 30,000 such children and young people are reported each year. This estimate is both too large, because it includes those with minor difficulties, and too small, because it excludes many who are not referred because of the lack of appropriate facilities.

When these and other factors are taken into account, it is my best guess that approximately 12,000 children and young people are in need of psychiatric treatment at any one time

* Presented at a meeting at the Community Church, New York City, April 20, 1954.

in the city of New York. It is also my best guess that the number of children receiving continuous psychiatric treatment in our city is approximately 3,000. In other words, one out of four who need treatment gets it.

There is a special urgency about these problems at this moment in our own community as well as in world affairs. Two World Wars have left us with a heritage of vast, unsolved psychological difficulties. Though the profound and compelling needs of mankind have brought an increase in the knowledge and tools at our command, we are far from having achieved a balance between the forces that make for tension and conflicts, and those that make for peace and stability.

The fear and insecurity that the atomic weapon has engendered have brought home to us that the only hope of harnessing this great source of energy in the interests of mankind lies in the character of man. Hitler taught us that the causes of war and conflict lie not only in political and social forces, but in the hearts of men and in human values.

The influence of social values in conditioning our attitudes to children is illustrated by two incidents that occurred in professional journeys to other countries not so long ago.

In one of the larger cities in Central Europe, I was being taken on a tour of children's institutions by the local director of welfare. We visited an infants' home which had in care about forty tots under two years of age. I noticed in one of the cribs a bouncing boy of a year or so. I remarked to my guide that this baby seemed so well endowed that he would soon be placed for adoption. His response was that adoption was out of the question; the child's mother was a woman of ill-repute and he was illegitimate. Since I found it hard to accept the logic of the situation and the reasons why the welfare department could not give the child this opportunity, my guide went on to say that heredity determined behavior and character, and that, therefore, this child could not be placed for adoption.

In contrast to this experience, and the lack of faith in children that it reveals, let me tell you of another incident that took place the following summer:

On a warm summer afternoon, some colleagues and I had been traveling in a car all day visiting child-welfare estab-

lishments in a Near Eastern country—one of the products of the maelstrom of the last war. It was a hot afternoon and we were parched. We decided to stop at a coöperative settlement for a glass of water. Arriving at the gate, I noticed fields of banana trees. I had been away from home for five weeks and suddenly felt a compelling desire to taste a banana. I found my way to the door of the community kitchen, and spoke to one of the helpers there. She was very courteous, but when I told her what I wanted, she was quite firm and answered, "Bananas are for children only."

When we face this interrelationship of men and society, and how they shape each other, we find ourselves in a vicious circle. Man makes society—society makes man. The only way that we can break the circle is to work at both at the same time—improvement in the character of the individual and liberalization of the society to which he belongs. If we had enough knowledge and enough authority, perhaps we could remake the social order to serve more fully the needs of man. But we have not either, so we have to be content with working on limited aspects of the vast problem.

These limitations both of knowledge and of authority come home to us when we tackle the problem of prevention. We do not know enough, but yet we do not make full use of the knowledge we have.

It is generally agreed that our basic knowledge of human behavior, and more particularly of mental illness, is not yet sufficient to serve as a sure basis for prevention. We have not yet been able to establish cause-and-effect relationships, in the same sense that we have for many physical illnesses. Thus, we have isolated the causes of typhoid and malaria, and we can be certain that if we eliminate the conditions under which these diseases breed and multiply, we can prevent them.

We are far from this stage in our knowledge of mental illness. Because of the fact that we do not know its causation, it is impossible to make a clear classification of the types and forms of mental illness. Thus, we do not know if schizophrenia is one disease or many, and there is much difference of opinion to-day as to whether it is basically due to certain constitutional factors, or to life experiences, or to combinations of both. But though our knowledge of causation is incom-

plete, it is wrong to assume that we do not know a great deal about the factors behind many forms of mental and emotional disturbances and character disorders, or about the many elements that enter into healing and recovery.

We also know a great deal already of what contributes to the healthy psychological growth of the individual. Thus, we believe that many forms of neurotic behavior are the product of the life experiences of the individual, particularly the quality of mothering that he receives as a young child, as well as the character of his relationships with his two parents. Of importance, too, is the broader environment in which he grows up—the school and the community.

While we have no complete scientific framework for preventive effort in mental health, yet there is agreement about some basic ideas. For instance, the healthier the individual is, the more he becomes an effective carrier of mental health to others. It has also been accepted that the relationships of one individual to another—both those specifically designed as therapeutic, such as that between patient and healer, and those that may occur in the normal course of living—are potent factors in prevention as well as in recovery.

Accordingly, we see preventive activities grouping themselves under three broad headings: (1) those designed for the protection of family life and the growth of the child in his earliest years; (2) those focused on the betterment of social institutions, especially institutions that share in the child-rearing function; and (3) those concerned with increasing the understanding of mental-health factors by the professions that deal with human beings.

Now I would like to tell you how one of the more important scientific findings about the growth of children can serve as a foundation for a many-sided and fruitful effort in prevention. When the bombing of British cities began, the British took steps to remove the children from London. The foster parents to whose homes these children were evacuated were faced with many behavior problems and some children had to be returned to their homes. At the same time, too, Anna Freud had established the Hampstead Nurseries for young children near London. As she studied the problems of the children in her nursery school, as well as those who were evacuated, she

came to a number of conclusions, the most important of which was that there was one experience to which the children had been subjected that could be worse than the shock of bombing. Separation from parents under certain circumstances could be the more damaging emotional experience.

Before we weigh the full significance of these findings for prevention, I should like to refer to one other scientific investigation. In 1937, Dr. David Levy published a paper on "affect hunger," which stimulated a number of studies in this country and abroad. The one that I know best is that conducted by Dr. William Goldfarb on children who were separated from their parents and deprived of affection during their early years. These studies established the fact that children so deprived failed to grow intellectually or emotionally at a normal rate. They have been described as emotionally flat, capable of only shallow attachments to other children or to adults.

These findings have alerted us to the importance of avoiding separation of young children from their parents. When separation becomes unavoidable, the child should be adequately prepared for the experience in order to diminish the trauma. Infants are no longer placed in institutions, whenever foster homes can be found. The quality of care that children's institutions provide has also been influenced. The sick child, too, should be prepared for the hospital experience. Hospitals should encourage mothers to stay with their children as much as possible, and frequent visiting should be encouraged.

Our experience at Hawthorne Cedar Knolls Schools has yielded other important findings which should prove valuable in efforts to improve child-rearing institutions.

Residential-treatment programs like that of Hawthorne teach us how to assess the impact of total life experience upon the behavior and growth of the individual. Here we can see how the social milieu and the order of living can be designed to foster healthy development. While it is beyond the scope of our discussion here to go into detail about the full meaning of this experience for prevention, I would like to touch briefly on some of the useful things we are learning and how this knowledge provides us with a starting point for selecting the positive and negative elements in social situations in which

children are reared. In the long run, this kind of experience can be a starting point, in safeguarding human values, in social planning, and in guiding social change.

Our work at Hawthorne has confirmed many of the accepted ideas as to the things that children need for healthy growth. We have seen at Hawthorne that the child must have a feeling of protection and know that the adult always stands back of him, ready to help him in any difficulty. We know that regularity and predictability in the order of living are important elements in his sense of security. We know that he needs understanding and tolerance of his behavior, whether it be bizarre or conforming. He needs opportunities for creative expression. He needs the approval of his peers.

If the public school and the nursery school could be examined and evaluated in the light of these facts that we have learned about children, many changes would be found necessary, and if these changes could then be carried out, these institutions would help children more than they do now. Thus, we believe that the teacher in the public school is the crucial person in the child's school experience. The kind of person the teacher is, and the degree to which he is free to understand and support each child, will determine the value of the experience for the child. It is our conviction that our public-school system must restore the teacher to his important place. If he is to fill this rôle, not only must he be carefully chosen, but he must not be overburdened. The organization of the school system itself needs to be recast so as to further these goals. The emphasis on the rôle of the teacher does not deny the need for additional services that can be offered only by other special workers in the school system. When we examine our own school system, we find that provision for these services has always been below any reasonable standard. At least one mental-health worker to every 1,500 children should be the irreducible minimum.

The problem of where to focus preventive efforts involves many considerations and judgments, the availability of funds and staff, and the readiness of the groups involved. As we have seen, prevention should begin with the earliest years and should embrace programs for the guidance of parents and the training of the professional workers who deal with young

children, such as the pediatrician, the public-health nurse, and the nursery teacher. We see these professionals as standing next to parents themselves in their capacity to influence wholesome child growth. In recent years, obstetricians and pediatricians have begun to concern themselves more consciously with ideas and methods that facilitate healthful emotional relationships between mother and infant. Indications of this trend can be seen in the living-in arrangements at maternity hospitals, the self-regulating feeding of infants, and the delayed and less abrupt methods of weaning and toilet training.

Our own agency has engaged in a number of collaborative projects with other professional groups which we believe have yielded valuable dividends in increased understanding of child behavior as well as of child protection. I should like to describe briefly one of these enterprises.

The Council Child Development Center provides consultation to community nursery schools. The main emphasis is not on diagnosis or treatment of individual preschool children, but on help to nursery schools in doing a better job for all the children in their care.

The staff of the consultation unit includes the following types of professional worker: (1) a psychiatrist, specially trained in dealing with problems of young children, (2) a pediatrician, (3) a psychologist, (4) a consultant in nursery education, and (5) a psychiatric social worker.

Briefly stated, the working process is one of close collaboration between the professional workers who constitute the team and the nursery staff.

Not only have significant changes in attitudes resulted from this kind of teamwork, but there have been many specific changes in the activities provided the children. Thus, there are shifts in the pace of activities, so that there is a better balance between periods of heightened and of diminishing activity, which thereby coincide more closely with the physical and emotional rhythms of the children. An increased use of plastic materials in the light of what these offer to the children, and of water-play where before it had not been permitted, high-light some of the concrete modifications in attitude and program.

Though preventive activities will ultimately prove the most

profitable, the plight of children already disturbed presents a more urgent claim on our attention for immediate planning. Furthermore, at this point there is no clear demarcation between many forms of prevention and treatment. Reaching children when trouble first shows itself is preventive as well as therapeutic; the mentally healthy individual or the person restored to mental health become a potent force for prevention. Not only disease, but health, too, is infectious.

We have mentioned the large number of children denied treatment and the wide gap that exists between the demands for treatment and the facilities available. The experience of our own agency, as well as that of all other mental-health groups, indicates that the demand for treatment began to mount during the last two years of the war and has continued to increase progressively ever since. As a matter of fact, no one knows the extent of the need that would come to light were sufficient facilities known to be available. Many parents do not apply because of the long waiting lists. Thus, in our own agency, we can at best treat only one out of four children for whom help is requested. This lack of sufficient treatment resources continues even though there has been growing appreciation on the part of the government and of the general public of the need for mental-health services and despite the actual increases in the amount of such service available.

Thus, within recent years we have seen an expansion of hospital and clinical facilities, an enlargement of the treatment clinic in the children's court, the establishment of the New York City Youth Board program and of other treatment facilities, as well as training and research programs made possible through the federal mental-health program.

In spite of the widening public interest in the mental-health problem and the participation of government in planning and providing treatment, we in New York City lack any over-all planning body. Such agencies as the Citizen's Committee on Children, the Welfare and Health Council, the New York State Mental Health Commission, and the New York City Youth Board, have all tried to approach the problem from the community standpoint, but these efforts have not yet yielded an over-all community plan.

It is my hope that the formulation of such a comprehensive plan will be hastened through the establishment of the recently enacted New York State Mental Health Board. What may prove to be the most far-reaching measure in the mental-health field to-day was enacted at the last session of the New York State Legislature.

Under this plan the state will appropriate up to $1 per capita to be matched with an equal sum by the local community. The funds thus made available are to be used for the expansion of mental-health services which are to be broadly interpreted and to include outpatient and inpatient treatment services, and provisions for training and research. The program is to be administered at the local level by a mental-health bureau, which is to consist of the heads of appropriate city departments, representatives of voluntary agencies, and private citizens. The mental-health bureau is also empowered to initiate new services, as well as to enter into contracts with existing agencies for additional services.

Obviously this kind of program cannot be fully effective unless it is designed and carried out in accordance with a community-wide master plan. The kind of plan we have in mind would maintain a continuous inventory of needs, spelling out the steps that must be taken and establishing priorities as between these various needs and the strategy of planning itself.

Thus, such a plan should indicate focal points on which efforts should be concentrated. What proportion of the available resources should be devoted to prevention as against treatment? Should the emphasis be on more residential care? Or should it be on more clinical services in the community itself before any additional residential-treatment centers are built or established? What is the best allocation of funds as between services for preschool children, for school-age children, and for adolescents? Since training of personnel and research are also needed, as well as treatment, then what kinds of project will yield the best results?

Basic needs in the mental-health field that have always had to be planned for are funds, facilities, and personnel. Although many of you may not agree with me, I believe that in 1954, in New York City, the order of importance of these

needs may be different from what it was two or three years ago. At that time we would have considered funds as the most pressing problem, but I do not believe that this would be as true to-day.

As we have seen, substantial additional funds have been and are being made available through taxation. It is also true that to a greater degree parents are willing and ready to pay for services. As of to-day, in my opinion, the order of the needs would be, first, a greater supply of skilled professional personnel; second, adequate treatment facilities; and third, additional funds.

Because mental-health problems cut across so many phases of our common life and take so many different forms, both preventive and treatment facilities must include a variety of agencies, employing diverse methods and focused on the problems as they present themselves in place and time.

Let me illustrate: If you want to help preschool children, from the standpoint either of prevention or of treatment, you must bring your services into the infant-health center and the nursery school. If you are interested in delinquency, you must establish your recreational, psychiatric, and other services on a local community or neighborhood basis, with the school perhaps as the focal institution. In dealing with this problem, you would also have to make sure that you have set up machinery for bringing service to the youngsters in trouble as early as possible.

One important gap in our community-wide treatment program to-day is the lack of sufficient residential-treatment centers. As we begin to tackle this problem, we are caught in what seems to be a dilemma. On the one hand, we are confronted with the pressing need for more institutional treatment for delinquent children who are a risk to themselves and to the community, and more residential centers for the treatment of seriously disturbed sick children who, if they remain in their own homes, may be headed for mental illness and may ultimately be committed to state hospitals. On the other hand, as we begin to plan additional facilities, we are faced with the fact that no child should be assigned to residential treatment who can possibly remain at home and be helped on an outpatient basis. If we add residential facilities without

at the same time augmenting outpatient services, we run the risk that residential treatment may be misused and children unnecessarily removed from their own homes.

Moreover, we know that if residential treatment is to be provided, it must be terribly expensive. Therefore, we should not undertake any elaborate expansion of residential treatment until we are certain that adequate outpatient services are available to meet the needs of every child as soon as those needs come to light.

These and like considerations make it clear that we should move carefully in the development of additional facilities and if choices are still possible, we should concentrate on extension of outpatient facilities first, and at the same time should work for improvement of the quality of care given to many children already in institutions.

In the final table of priorities, we must give weight to what might be termed the strategy of planning. It is important to add facilities, but it is equally important to make those facilities contribute to the utmost to the total program, to the need for trained personnel, for example, and for research into treatment methods.

An example of this kind of planning is our Henry Ittleson Center for Child Research, which was established last year. We began with the need for additional treatment facilities for severely disturbed children in the younger school-age group. In designing this project, however, we tried to make sure that it would serve as a lever to improve the level of all residential treatment in the community. We planned, therefore, not merely to provide treatment, but to do so under the most favorable circumstances, so that it might constitute a model program. We decided that we would learn more if we began with a small group and worked with the youngest children. We planned a program that would utilize the most comprehensive methods of study as well as all well-founded treatment procedures, including close and continuous work with parents. In doing so, we hope to stretch the limits of treatability, to demonstrate that certain kinds of sick children can be cared for in an open environment outside of the locked ward. We have given an important place to careful investigation into the nature of the child's problem and the factors that may

account for it. Moreover, we planned for the training of all the different types of professional worker that participate in the program.

By planning our project in this way, we hope that it will make a significant contribution to the total field, over and beyond the help it will give to the children in its care.

In my opinion the shortage of qualified professional workers for mental-health services remains the number-one problem in the field to-day. This is true even though an increasing amount of planning and funds are being devoted to enlarged training programs which have already yielded an increase in the number of workers in the specialized mental-health categories.

The number of psychiatrists in the United States over the past decade has increased approximately from 3,200 to 7,600, or more than doubled; the number of psychologists has increased from 4,800 to 9,300; and the number of psychiatric social workers, from 600 to 3,000. The increase that has taken place, however, does not begin to keep pace with the need.

Since is it clear that we have not enough trained workers, it becomes the more imperative that we make the fullest use of those we have.

There are two problems that, I think, stand in the way of the fullest exploitation of the available professional skills in this field. I am referring to the division of labor between the psychiatrist and the other professions involved in child guidance and in child treatment, and the proportion of time that qualified psychiatrists devote to community service.

The division of labor between the psychiatrist and the other professions is a subject that touches off a good deal of controversy, and I merely wish to refer to some of the more objective facts. What I have in mind is the division of responsibility between the psychiatric social worker, the psychologist, and the psychiatrist in carrying out the treatment with the child and his family. Some of the pertinent facts are well known. There are not enough child psychiatrists at present, and there are not likely to be for a great many years, to carry the responsibility for psychotherapy. Psychiatric social workers, functioning in a team relationship with the psychiatrist,

have demonstrated their ability to carry this responsibility with marked success. In the light of these two facts, I believe that the training of psychiatric social workers for the psychotherapy of children should be frankly undertaken. Enough safeguards can be and are being established to assure responsible practice.

Our own agency has followed the division of labor that I have suggested for over two decades. Psychiatric case-workers, working in a team relationship with psychiatrists, have carried the bulk of the responsibility for treatment, including psychotherapy. To safeguard this kind of practice, we provided a comprehensive training and supervisory program. The validity of our method of work has been sufficiently established to provide a pattern for the field, and many agencies are following in our footsteps.

Clarification of the kinds of skill and the necessary training that are required for child guidance and psychotherapy with children, as well as essential safeguards through team practice, would be one step toward the licensing of the various non-medical professions for private practice in this field.

Assuming that the division of labor between the psychiatrist and the non-medical therapist that we are advocating were to be widely adopted and implemented in the field, there is still one other factor that I believe stands in the way of the fullest use of the time of the qualified psychiatrist, who remains the key person in the development of mental-health programs, as leader, teacher, and chief clinician.

While no precise study has been made, it is my own impression—and one that is generally shared—that by far the greatest proportion of the time of the psychiatrist is invested in his private practice and in treatment of a limited number of patients. If the ratio between his private practice and his community work could be changed, it could increase substantially the amount of psychiatric time available for community services.

While at the moment we consider the scarcity of trained personnel as the number-one problem, rather than financial resources, the time may not be far off when economic factors will again loom large. Even though a greater number of parents are able and ready to pay in part or in full for serv-

ice, the fact remains that if all children in need are to be helped, the largest proportion of treatment will for some time have to be provided on a free basis or at least subsidized through philanthropic or tax funds.

It is my hope that in the long run, psychiatric treatment for children will be available on the same basis as all health care, and will be part of whatever general health programs are devised in this country to meet the health needs of the general population. Group-care and health-insurance programs will in time include psychiatric treatment as a basic provision.

THE RELATIONSHIP BETWEEN LEARNING AND EXPRESSION OF SELF-ORIENTED NEEDS AT A MENTAL-HEALTH-EDUCATION WORKSHOP

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THIS is the third paper in a series concerned with research into the effectiveness of mental-health-education techniques.

The first paper discussed the goals of mental-health education as selected by a group of experts[1]. One of the major goals thus selected—the promotion and maintenance of good mental health in children—served as the basis for a mental-health-education workshop held in Michigan in the spring of 1953. Specifically, this workshop attempted to acquaint parents, teachers, and public-health nurses with the general phases of psychosexual development, the meaning and use of the concept of permissiveness, and the need to channelize aggression into constructive behavior.

The workshop was accompanied by a research project designed to evaluate the effectiveness of different methods of presenting these child-rearing concepts to the participants. The research was divided into two major phases: (1) the measurement of increment of information and its generalization for the topics under discussion; and (2) the observation of self-oriented needs expressed by participants and the effects of these needs on achievement and assimilation.

The second paper in this series presented a description and discussion of the research design, and the results of the first phase of the study.[2] Briefly, these results indicated that the

[1] See "The Goals of Mental-Health Education Commonly Selected by a Group of Experts," by Gwen Andrew and Esther L. Middlewood. MENTAL HYGIENE, Vol. 37, pp. 596–605, October, 1953.

[2] See "A Study of the Effectiveness of a Workshop Method for Mental-Health Education," by Gwen Andrew. MENTAL HYGIENE, Vol. 38, 267–78, April, 1954.

workshop was effective as a method for presenting such material, and that lecture-type presentations were the most effective of those studied—*i.e.*, lecture, film, records, and panel discussion. Four types of leadership or "resource person" were used in small-group discussions that followed the general sessions, and it was found that members of leaderless groups showed the greatest achievement in learning.

Results obtained from learning experiments contribute much to the planning of mental-health-education programs. However, in addition to the intellectual aspects of learning, it is essential to consider the motivations of the individuals who participate in such training. The two-way relationship between the influence of individual motivations on group discussion, and, conversely, the influence of group discussion on the motivations of the individual, presents an intricate problem that needs study if the effectiveness of the workshop method is to be maximized. Such study would appear necessary, especially in planning instruction that evokes the ego involvement inherent in discussions of personality and its development.

It is assumed, on the basis of present theory, that verbal expressions are indicative of self-oriented needs, and that intensity of need is related to degree of verbalization. Proceeding from this assumption, two major hypotheses were drawn for the second phase of the experiment:

1. Strong motivation to satisfy self-oriented needs, as indicated by verbal expression of these needs, results in limited learning of subject material,

2. The greater the satisfaction of self-oriented needs, the greater the learning of subject material.

Methodology.—The observation method used in the present study is an elaboration of the technique developed by Fouriezos, Hutt, and Guetzkow to evaluate the self-oriented needs expressed by individuals in small groups.[1] For the present experiment, self-oriented needs are defined as verbal expressions directed primarily toward the satisfaction of the individual's needs, regardless of their effect on the group.

[1] See "Measurement of Self-Oriented Needs in Discussion Groups," by Nicholas T. Fouriezos, Max L. Hutt, and Harold Guetzkow. *Journal of Abnormal and Social Psychology*, Vol. 45, pp. 682–90, October, 1950.

These needs are classified as dominance, aggression, status, catharsis, and dependence. Comprehensive definitions were prepared for each classification, based on those offered by the foregoing authors.

A team of observers, consisting of eight practicing clinicians who were either psychologists or psychiatric social workers, was selected to record the needs expressed by each workshop member. Each observer was permanently assigned to one of the eight small discussion groups that met immediately after each of the four general sessions at which subject matter was presented. The observers were instructed to note briefly the verbalizations made by each individual in the group and to indicate what need, if any, was being expressed. In addition, each observer noted the need expressed most predominantly by his group as a whole. This observational procedure included (1) a continuous report of the predominant group needs expressed *during* a session; and (2) an over-all evluation of the group *after* each session for the one need most commonly expressed.

The discussion groups were conducted according to one of four types of leadership—the group-oriented leader, the leader who answered questions only, the leader who acted as an authority and directed discussion, and the leaderless group. In an attempt to control leader and observer bias, two discussion groups were established for each type of leadership. The effect of the different types of leadership was measured both through the tested learning of the members of the groups, and through observations of the needs expressed by each individual.

At the close of the workshop, the observer rated each participant on a ten-point scale according to the degree to which his verbalizations indicated self-oriented needs. He further indicated the one need that was most predominant for that individual.

At the first general session, a thirty-item, multiple-choice test, covering the material to be presented during the course of the workshop, was administered to each participant. This test was readministered at the close of the workshop to give a measure of the learning that had taken place. The reader

is referred to a former article for a discussion of the construction of this test, the results of which were used for both phases of the workshop experiment.[1]

Reliability of Observers' Ratings.—A manual that provided comprehensive definitions of all terms used in the study, and that included a complete outline of the observational procedure, was submitted to each observer well in advance of the meeting. Unfortunately, it was not possible to hold an advance workshop to test the comparability of the observers' judgments, but a method was worked out to determine their agreement. Each observer was given a script of a group scene from the play, *Abe Lincoln in Illinois*,[2] and was asked to carry out the analysis of self-oriented needs as explained in the manual. These scripts were collected and compared for agreement in judgment of the needs expressed. Unusually high agreement was found (X^2=72.5), indicating that differences between workshop groups could not be attributed to differences in observer reliability. Further to insure comparability in observer methods, a training session was conducted immediately prior to the workshop in order to clarify definitions and insure uniform procedure.

Degree of Self-Oriented-Need Expression and Measured Learning.—Several analyses were made to determine the relationship between increment of information or learning and the degree to which an individual's verbalization were motivated by self-oriented needs.

It was found that the higher the rating on self-oriented needs, the lower the score on the post-workshop test (Pearson r=.70). A negative relationship was also found between the expressed self-oriented needs and the amount of improvement on the post- over the pre-workshop test. Interestingly, there was a positive correlation between degree of self-oriented-need expression and results on the pre-workshop test (Pearson r=.50). This result might imply that the increment of information that took place was directly a result of the level of knowledge in the first place, and hence that those participants who were best prepared at the beginning of the workshop (high self-oriented-need group) were penalized by the

[1] See Andrew, *op. cit.*

[2] *Abe Lincoln in Illinois*, by Robert E. Sherwood. New York: Charles Scribner's Sons, 1939.

final testing, in which their chance for improvement was actually smaller than that of the less well informed (low self-oriented-need group). To avoid this complication, the improvement between first and second tests was measured by the Hovland effectiveness index, which relates improvement to improvement possible, rather than on the basis of absolute differences.[1]

These results, then, indicate that participants who largely verbalized their own needs were somewhat better informed at the outset, but they did not learn as much as did those participants who were less motivated to express their own needs. These analyses lead us to accept our first hypothesis that strong motivation to satisfy self-oriented needs, as indicated by verbal expression of these needs, results in limited learning of subject material.

The relationships presented focus attention on the intricacies of planning an effective mental-health-education program. It appears that many participants, particularly those who are strongly motivated to satisfy their own needs and who are informed at least partially about mental-health principles, will find it most difficult to correct misconceptions. It would seem that the most effective technique for a workshop of this type would be that which primarily attempted to satisfy self-oriented needs while presenting subject matter.

Predominant Self-Oriented Need and Learning.—A discussion of self-oriented needs should concern itself with an analysis of the relationship between learning and the need predominantly expressed by an individual. It will be recalled that self-oriented needs were classified as aggression, catharsis, status, dominance, and dependency. To make the analysis of the relationship between predominant need and learning, the test results for all participants were grouped according to the predominantly expressed need, resulting in five groups.

Effectiveness indices were computed to determine the increment of information for each of the five need groups. By this measure, it was found that the need groups ranked as follows: catharsis, dominance, dependence, aggression, and status. Those participants whose predominant need was ca-

[1] See *Experiments on Mass Communication*, Vol. III, by Carl I. Hovland, Arthur A. Lumsdaine, and Fred D. Sheffield. Princeton, N. J.: Princeton University Press, 1949.

tharsis showed the greatest increment of information and so forth down to those whose need was status, who learned the least. The ranks must be considered as only indicative, since significance tests were not feasible with the small numbers of participants in each group.

As previously stated, it was hypothesized that satisfaction of self-oriented needs would result in greater learning. It was found that individuals who predominantly expressed certain needs learned more than did those who expressed other needs. The question then became: Were these needs that were related to greater learning better satisfied than the others? The next investigation considered the relationships between types of group leadership and the expression of predominant self-oriented needs.

Results from analysis of observer reports indicated that the leaderless groups provided the only setting in which a workshop participant had ample opportunity to express his self-oriented needs, and that there catharsis was the need most acceptable to other group members. In other words, where no leader was present, each group member was able to express himself with relative freedom, and those who wished to satisfy a need for catharsis were accepted by other participants with little restraint. Once the leaderless groups were organized, aggression and dominance were expressed infrequently. There appeared to be little attempt to achieve status, perhaps because the group members were acquainted prior to the workshop. Some dependency need was evident, but this tended to disappear with discussion, and the two leaderless groups organized into continuous cathartic sessions. Thus, those individuals whose predominant need was catharsis, and who were members of leaderless groups, had considerable opportunity to express their need and to have the need met, since there was group acceptance of it.

The remaining four needs were expressed more often by members of the other groups which had various forms of leadership (group-oriented, authority, and question-answer). The needs of individuals in these groups were often suppressed by other participants and by the leaders' attempting to achieve the goal of discussing material pertinent to the subject matter presented in the general sessions. Catharsis

was permitted infrequently. Aggression, status, and dominance were often repressed in the face of group disapproval. For groups with the various leaders, no relationship was found between leadership and the predominant needs expressed by individuals. Apparently, then, satisfaction of self-oriented needs results in greater learning. At least, this is true when the need is catharsis, which can be satisfied relatively simply.

From these results, it appears that a most effective workshop method consists of subject-matter presentations in general sessions followed by non-structured, leaderless discussion groups in which members freely discuss problems about which they feel concerned. Individuals whose needs are of an aggressive or dominant nature may not be well enough accepted by other group members to permit need satisfaction. Here, other techniques may need to be devised, providing for need satisfaction within the frame of a discussion group.

To summarize, these analyses demonstrate that catharsis is the need most readily satisfied in group discussion and that those individuals who satisfy this need learn more than do other workshop participants. Further, self-oriented needs are most acceptable in small discussion groups in which no professional leader is present. From these and former data, it is to be concluded that the most effective workshop is that which offers lecture-type presentations of material, followed by small-group discussions in which there is no professional person acting as leader or resource person. This structure offers information that participants may assimilate during free discussion of problems about which they are concerned.

THE RÔLE OF THE FAMILY IN RELATION TO THE INSTITUTIONALIZED MENTAL PATIENT*

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A QUESTION has arisen as to how well we are applying the current theories of social interaction to treatment of mental patients in mental institutions, or whether we are still thinking in the old terms of the individual in isolation. Many names arise in this connection—the theoretical contributions of Sullivan, Horney, Slavson, Pollack, Fromm-Reichmann, and others. As Murphy and Cattell have said, "When clinical psychiatry appeared as an entity, in the hands of Emil Kraepelin, the disease was inside the patient, just as an ulcer or a tumor was inside him; . . . with Freud the phenomena of transference began to make embarrassingly clear that two persons were involved in every sympton and in every step toward cure, the analyst serving as temporary surrogate for the persons who were or are the psychosocial reality of the patient; and . . . with Sullivan the conception of a disease inside the person, carried around by him intact from one situation to another, was frankly abandoned, with a clear recognition that all we really see and deal with is a career line of interactions between individuals; and . . . if this be so, it is the relationships, not the individuals, that become our concern."[1]

In this paper, we wish to discuss the rôle the family may play in the therapeutic process, particularly in terms of the institutionalized patient. This matter has been more clearly defined in relation to the treatment of children. The emphasis of the Freudian has been on the early formative years of the

* The authors wish to express their thanks to Dr. Francis H. Sleeper, Superintendent of the Augusta State Hospital, for his helpful suggestions.

[1] See "Sullivan and Field Theory," by Gardner Murphy and Elizabeth Cattell, in *The Contributions of Harry Stack Sullivan*, edited by Patrick Mullahy. New York: Hermitage House, 1952. p. 162.

child, and the emphasis on family relationships has naturally followed. However, the life process is one of continuing social interaction and mutual influence. Therefore, it is the belief of many that the adult, as well as the child, can be treated intelligently only if the total social constellation is considered.

The following brief case histories summarize some of the problems that we wish to raise.

Case A.—Recently a young woman patient was out for dinner with her mother and sister in a restaurant near the hospital. There also happened to be, in the same restaurant, some members of the hospital staff. The girl flushed with pleasure as she saw the members of the staff and rushed to introduce them to her mother and sister. The sister drew back and gave them a cold response, making it clear that she couldn't wait to get away. The mother looked embarrassed and ashamed and barely acknowledged the introduction. The patient's face reflected her disappointment.

Case B.—A female patient in the hospital described her Thanksgiving Day as follows: "Somehow I just couldn't eat the Thanksgiving dinner here—there were so many people and the table just didn't look very festive. I sat until the food grew cold. I tried very hard to eat, but just couldn't take a mouthful." When questioned further, the patient said, "I guess I really couldn't eat because I had expected to go home for Thanksgiving dinner and my mother just couldn't find time to come and get me." This patient lives less than one hour's drive away from the hospital.

Case C.—A nine-year-old boy recently questioned the writers about the mother of a schoolmate who is a patient at this hospital. He wanted to know whether Jackie's mother was still "quiet and not talking to anybody like when she got sick? Why can't Jackie go to see her? He misses her very much." We then explained to him the hospital regulations which would not allow Jackie to visit his mother. The little boy exclaimed, "But that's wrong! If she is going to *want* to get better, she has to see the one she loves the most."

Case D.—This patient is a woman in her early forties, who is married and has two young children. She and her husband have always lived with the patient's mother. The mother is an overbearing, domineering woman who has run every detail of her daughter's life. It was noticeable that whenever the patient's mother visited, the patient became upset. This mother was told, by the psychiatrist, that her visits would be prohibited and that hereafter, the husband should visit his wife frequently, but unaccompanied by his mother-in-law. The patient has shown noticeable improvement with this arrangement.

Case A cited above exemplifies the problem of the stigma and shame attached to mental illness. Despite the fact that most of us feel that we have moved a long way from the ancient

belief of *possession by devils* and all of the superstitions connected with mental illness, there are still, more prevalant than not, feelings of undefined fear and shame. What are some of the reasons for these fears? It is felt by many that the incidence of mental illness in their family implies an unsound hereditary structure. They cannot accept this, since it seems to be a direct attack upon their personal integrity. There are also unconscious feelings that mental illness is a retribution for *sin*, tending to stir up guilt feelings in members of the family, arising from their own conflicts as well as their conflicts in relation to the patient.

At Augusta State Hospital efforts have been made to mitigate this problem. All families receive copies of the excellent pamphlet, *When Mental Illness Strikes Your Family*, by Kathleen Doyle.[1] Great care has also been taken in the selection of receptionists and their instruction in dealing with families and visitors. In addition, despite opposition from various groups, the superintendent of this hospital has utilized Hospital Day as a means of helping to remove the stigma of mental illness in the eyes of the general public. The doors are thrown open to the public, and for the last five years hundreds of people have come to the hospital and been taken on tours through the wards where hospital routine is explained. Movies and talks are given by the various departments, and there is a general exhibition, defining the rôle of each department by means of photographs, graphs, and printed material.

Although these efforts are salutary, the problem is far from solved. In particular, the family of the mental patient must receive careful, individual counseling in this connection. Although in general there is a common basis for the feeling which can best be handled by public education, the family has its own unique background which must be dealt with.

Upon admission, the patient enters a new and unfamiliar world. The literature is filled with subjective accounts of this experience.[2] How does the mental-hospital environment

[1] New York: Public Affairs Pamphlet No. 172, 1951.

[2] See, for example, Clifford W. Beers's classic, *A Mind that Found Itself*, first published in 1908 and later reissued in numerous editions; Harold Maine's *If a Man Be Mad*, (New York: Doubleday and Company, 1947); and Mary Ward's *The Snake Pit* (New York: Random House, 1946).

differ from the home environment? It is evident that no matter how well organized the hospital may be, the environment is an abnormal one when compared to that with which the patient is familiar. The first thing that happens to the patient is that he loses his liberty—doors are locked; windows are barred; personal, sentimental, emotionally valued objects are taken from him, such as wedding ring, wrist watch, eyeglasses, and so on. Though these are eventually restored, the initial emotional impact is great. The patient cannot, for some time, structure the hospital environment. There is, from the beginning, a loss of identity; our patient becomes one of many. Some patients settle into this anonymity with relief, particularly many schizophrenics whose effort to withdraw from life is abetted. But there are others who continually resist this loss of identity and thus often make a "poor hospital adjustment."

When the family visits, the patient once more may emerge as an individual, with his own unique background and love relationships. The family is the embodiment of this patient's particular sub-cultural heritage, personality development—in fact, his whole being. We have found that there is a direct relationship between the patient's acceptance of or resistance to loss of identity and his reaction to his family. The patient who accepts this loss tends to resist his family. It is especially important in these cases that the staff explain this to the family and do everything possible to prevent loss of interest on their part. Despite lack of response, the family must be encouraged to continue their visits, helping to reassure and motivate the patient to differentiate his environment. For nine visits he may not visibly respond to his family, but on the tenth visit he may be ready to talk with them, and the family must then be available to give him the support he needs. Presence alone is not the answer; the family must also give the patient warmth and understanding. While love is essential, as Bettelheim has said, *love is not enough*,[1] but the understanding, which is also a necessity, must be given to the family in large part by members of the hospital staff. Too often the family loses interest and the patient is *lost* on one of the chronic wards. Also, it is usually true that, be-

[1] See *Love Is Not Enough*, by Bruno Bettelheim. Glencoe, Illinois: The Free Press, 1950.

cause of shortage of personnel and the usual human frailties, the patient who gets the most consistent attention from his family also gets the most consistent attention from the staff.

In the efforts of the staff to impart understanding of the patient to the family, there are some general considerations that should be emphasized. For most people consistency in the behavior of those close to them is important, but for the mental patient it is even more important. In Case B, for example, what perhaps seemed a minor matter to the family was of major importance to the patient. In mental illness lack of faith in others is a predominant feature. This is why it is so important that when a promise is made to a patient, it must be one that can be kept. This is essential in restoring the patient's ability to relate to others with security.

The anniversaries that are of personal significance to the patient are also of importance. These include birthdays and wedding anniversaries, as well as holidays (Christmas, Thanksgiving, and so on) which meant much to the patient at home. It is not enough for the hospital staff and community volunteers to acknowledge these events. That is certainly helpful, but it is only the family that can invest the holiday with its personal meaning to the patient. These matters seem of small moment to those of us who habitually benefit from them, but deprive us of these small benefits and we feel hurt and rejected.

In many mental hospitals there is an understandable regulation that no child under sixteen years of age may be admitted as a visitor. To the young child these visits might well be traumatic. However, it is our contention that specific cases may give rise to a need for flexibility, as in the case of C cited earlier. This patient is a mother whose husband has deserted the family. There are four children ranging from six to fourteen years of age. The only link she has with the outside world is her children. This patient presents a clinical picture of withdrawal typical of the textbook catatonic schizophrenic. More specifically, in our terms, she is one of the patients who have lost themselves within the protective, impersonal world of the mental hospital. Means of motivating her to redefine her personal world have thus far not been found. It is entirely possible that, in this case, well-planned

visits with her children might open up such an avenue. Hospital regulations are necessary, but intelligent exceptions must be made when warranted.

Up to this point we have been discussing the inclusion of the family in therapeutic planning. There are other cases in which it may be advisable for certain members of the family to be excluded. Case D is an example of this kind. Fortunately, the doctor was aware of this particular family constellation and skillfully eliminated the visits of the mother. There still remains, however, the need of therapeutic counseling for this mother, who has been such a detriment to her daughter's health. Too often a patient is discharged into a family environment that was originally a salient contributing factor in the illness. Since the situation remains basically unchanged, more often than not we see the patient back at the hospital within a short period of time. In order to make more certain that, once discharged, the patient remains out of the hospital, we cannot afford to neglect the family situation.

We have attempted to bring the rôle of the mental patient's family into the foreground as an essential consideration in therapeutic planning. It is our contention that there is a peculiar situation of anonymity arising from the institutionalization of the mental patient. We are not negating the importance of interpersonal relationships within the hospital walls,[1] but we are contending that the patient's interpersonal relationships with his family are of special importance. The hospital, as such, is lifted from the main stream of life and, for the patient who will recover, it is only a transition between a past and a future in the community. Therefore, no matter how successful the interpersonal relationships of the patient within the hospital, it is his link with the outside world that must be strengthened. The family embodies the "normal" world of interpersonal relationships for the patient to which we hope to help him return.

[1] For a discussion of this, see "Milieu Therapy," by David Rioch and Alfred Stanton. *Psychiatry*, Vol. 16, pp. 65–73, February, 1953.

OBSERVATIONS ON THE SOMATIC AND PSYCHOSOMATIC SIGNIFICANCE OF GROUP ACTIVITY ON OLDER PEOPLE

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WE are now living in a new era—an era of an aging population. Programs for meeting the demands that rise out of this changing population structure call for a complete mobilization of community, state, and national resources. With the number of people who are over sixty-five increasing significantly each year, our society is to-day faced wit.. the problem of keeping a large share of its population from joining those whose minds are allowed to fade before their bodies do.

Consequently, the emphasis in this paper will be on the less tangible needs of the old adult—the social needs of companionship, creativity, and sheer enjoyment. The basis for many of the observations that follow have evolved from the author's experiences as group-work consultant to the Hennepin County Welfare Board of Minneapolis, Minnesota.

Mental Health and Group Activity.—Mental health seems to be related to outlets for companionship, usefulness, and creativity. On the basis of a number of studies that have appeared in recent years, it has been concluded that the maintenance of mental well-being depends, in part, on social communication. Yet the monotony and lack of stimulation from outside contacts in rural areas, and the intense competition, the anonymity, and the excess of passive entertainment in urban areas make positive social relations difficult for many old people. We now know that the well-being of any person cannot be met by food, shelter, and clothing alone. Our entire conception of social problems is being revolutionized by the realization that a close relationship exists between personality, mentality, and the normal functioning of the bodily organs. Every blow to the already failing powers of the

aging may force many subsequent visits to the clinic and the physician as expressions of the constant search for reassurance. There have been assertions by professionals as well as by older adults themselves that many old people have staved off deterioration and perhaps eventual residency in a mental institution because of the social stimulation provided through senior-adult groups. It is quite conceivable that if the community makes a concerted effort to provide opportunities for qualitative group contacts for the older adult, per capita medical and psychiatric costs may reach a plateau.

Again, there is evidence that emotional strains or deprivations may often be a precipitating factor in the appearance of some diseases that seem to be primarily organic in origin. This has been aptly described as a "need for illness," a state arising from repeated frustrations. These frustrations create a tension state which in turn affects the physical and mental functioning of the individual. Then, too, it has been asserted that some people are predisposed to, or may have an inherent susceptibility to, certain types of illness, which may or may not develop, depending upon factors in the environment that influence the physical and emotional well-being of the individual. In any instance, the importance of psychosocial factors should not be underestimated. This is not to minimize the importance of the irreversibility of brain damage—at least in our present state of biological knowledge—but rather makes it most imperative that we prescind from such conditions the contributing emotional factors that might have been avoided or at least alleviated. Observations and empirical evidence show that over-rapid senescence—which leads toward senility or degenerative diseases—may be controlled in some instances by an environment in which older people can meet their own needs in their own way.

In this paper "old and older adults" refers to those chronologically aged sixty-five and over, for traditional reasons only, since there are many functional ages, such as physiologic age, psychological age, learning age, judgmental age.

The "Preventive" Approach.—One major preventive approach is the provision by the community of a climate in which those older people who are active can continue to remain active. The same opportunities should be afforded to those

older adults who are no longer contributing to the community or who lack social communication. These opportunities can be made possible by bringing people together in a group. The Golden Age Club is one expression of the need for group belonging, and it has attained phenomenal growth within the past five years. And for many old adults, this senior-citizen-club group is their only significant social outlet. Also, there is a growing realization that congregate centers for the aged—apart from mental institutions—have in the past facilitated "degeneration" through lack of understanding of the wonderful potentials of resident group life. And even in mental institutions there is now a stirring—dim though it may be—to the potential afforded through group work with the senile or psychotic aged person.

Many people who have retired, either on a voluntary or on a compulsory basis, appear to deteriorate rapidly in social consciousness, physical appearance, or emotional stability, for lack of some meaning and pleasure in life. For example, several years ago a competent supervisor in a Minneapolis public-utility firm was, because of "company rules," retired at the age of sixty-five with adequate financial benefits. Although management admitted that his working skills had not diminished, his compulsory retirement "stuck." Six months later, he had his first "nervous breakdown." After a second breakdown, he was on the point of being voluntarily committed to a state hospital when he became acquainted with a group of retired professional and business people—the Old Guards. Here he found new companions who in turn motivated him toward new interests and a renewed zest for life. Here, fortunately, a "preventive" program was operating—a senior-adult club.

Belonging to a group is a natural and accepted pattern of living and yet many older people no longer have any group as part of their pattern of everyday living. The need for emotional satisfaction does not stop at any chronological age. And when the opportunity for such gratification is limited—as it is for too many old adults—a serious chasm develops between the desire to "belong" and the opportunity to do so.

Observations have been made in several cities on old adults who put aside their canes to dance and later picked them up

to walk. Many others have forgotten their earlier complaints about their ailments and have subsequently dismissed them in a maze of new interests. The seventy-four-year-old woman who prayed every night that she would not be alive the following morning, since she "had nothing to live for," now eagerly looks forward to seeing her new friends from a senior-citizen club.

General Medical, Psychiatric, and Social Group Relationships.—Community efforts are all-important, for they enhance the individual's and the family's efforts to provide for their own health and welfare. A social worker who was constantly bombarded by complaints from an older woman, such as, "That dance-hall sign was deliberately put up to annoy me," recognized the symptom of a developing aberration. She was able to interest the woman in a senior-citizens group—The Fellowship Club—after which there were no more complaints of annoyances such as the dance-hall sign. We suspect that the older-adult club played a valid rôle in the mental well-being of this woman. And when another group—The Friendly Club—is able to provide the motivating spark for a sixty-nine-year-old adult, so that she gets out of her bed for the first time in over a year, with an accompanying drop in medical expenses, we suspect further that the senior-adult club is an all-important adjunct to her physical well-being. Then, when there has not been a single commitment to a mental institution from upwards of 6,000 older-adult-group membership in a four-year span in Minneapolis, we cannot but feel that one possible solution to mental illness in old age has been found. Of course, such cause-and-effect relationships have yet to be scientifically established through experimental designs.

It is to be expected that the cost of medical services will increase as more older people live longer, since with age comes increasing susceptibility to chronic illness. But this is by no means the whole explanation. For example, one study of 200 members of a community center for senior adults in New York City indicated a drop in clinic visits of close to 50 per cent. Of course these findings must still be weighed with the variety of factors that necessarily influence medical-care needs. On the other hand, there *was* less preoccupation with

illness and there *was* a considerable decline in clinic attendance by these 200 participating members of the Hodson Community Center. Again, its first five-year report stated that there had been no admissions to a psychiatric hospital from its entire active membership during that period.

A social worker reported that a seventy-six-year-old man who lived alone in a light-housekeeping room was "just *beginning* to be a hypochondriac . . . [and] missed friends who had moved out of his neighborhood," but it was conceivable that a group could "still save him." And it appeared to do so, for a later history of this man reported that "he had found new friends through his club and seemed to take an interest in them rather than in himself only." The group, then, is perceived as a means to aid the old adult toward a proper balance of concern for "self" and for "others." Indeed, all types of group living on an organized basis, operating within the tenets of a functional democracy, have a unique contribution to offer the art of social living. The necessary ingredients of group life are missing for those who are lonely and alone. This loneliness and aloneness, which crosses all economic barriers or other social distinctions, is an even more poignant experience in the later years. Human beings at all ages need to have satisfactory relationships with other people and the center for these relationships is the group.

Congregate Living Centers.—Older adults residing in homes for the aged, in nursing or rest homes, and in boarding homes develop "institutionalitis." They become victims of having everything done for them by well-intentioned volunteers and unimaginative administrators, or of having nothing done for them, with a serious lack of opportunities to do anything for themselves. Subsequently they may find it difficult to react to anything and may turn "inward" with somatic complaints, and "outward" with symptoms like unkempt appearance. Recreation in its broadest sense, as anything that gives emotional satisfaction to the individual, has proved to be a stabilizing factor for people. When recreational opportunities are lacking within a home, interpersonal relationships are likely to be strained and unrewarding. Too, loneliness and lack of interests are found regardless of place of residence.

Dr. Wilma Donahue, of the University of Michigan Institute

of Human Adjustment, and her associates have demonstrated that somatic complaints and improved interpersonal relations can be correlated with the quality of recreational guidance within a home for the aged. A seventy-five-year-old gentleman, with extremely limited vision, who resided in a hotel catering to the blind, requested opportunities to be with others since "all they do is talk about themselves. I seem to be losing my grip because it's not 'normal' living."

Again, an eighty-two-year-old in a home for the aged complained, "There is just nothing for me to do. I might just as well be dead, listening to every one's problems." In this same home the administrator had stated that the residents were not interested in having anything done for them. Still, the newly appointed social-services director noted a perceptible decrease in requests for medical assistance after a well-planned recreation program had been in operation for some months. And the same eighty-two-year-old (then eighty-three) no longer had cause to complain.

In a further instance in another home, a sixty-eight-year-old woman increasingly refused to leave her room and gradually grew physically unkempt until a social-group activity was initiated. It took several months to get her to the point where she hesitatingly joined a handicraft group, "just to watch." This watching turned to active participation in the craft group and away from the continuous isolation of her own room. She once again took pains to "look nice."

It is being recognized more and more that our modern civilization, with its complex, changing cultures, plays an exceedingly important rôle in the etiology of mental illness. This can usually be traced to a lack of the sense of individual worth and dignity which invariably is derived from some type of social group. The use of this type of group, both to the senescent and to the senile, to the normal and to the psychotic, has in the past too often fallen into desuetude without a fair chance to prove its worth.

Only a few years ago, the suggestion that the senile aged could improve their social performance would have met with disdain. And yet the Montefiore Home for the Aged in Cleveland has made a beginning and a most worth-while contribution by demonstrating the social value of simple, repetitive,

group recreational skills. Here the principle of doing *"with"* people is modified to a degree so that it becomes more enmeshed with the doing *"for."*

Again, it too often has been assumed that the aged mentally ill are hopeless cases. And yet initial experiments such as at the Fergus Falls State Hospital, Minnesota, show the possibilities in the use of group techniques to speed up social communication. The rate of discharge actually jumped to more than four times the previous rates for the aged mentally ill during comparable time spans. Apparently it was not so difficult to maintain contact with these patients as has been assumed, and the patients' contact with the environment was strengthened by having them engage in group activity.

Then, too, it is quite important for former patients to be able to participate in normal social groups as well as in ex-patients' therapy organizations. There is indeed a major community challenge posed by older people who have been hospitalized and then returned to the community to lead lonely lives. One woman, aged sixty, had attempted to join church groups, but felt out of place, since the other people usually came in couples while her husband would not accompany her. She had a complete lack of social life. Another woman, aged seventy-one, lived alone in a hotel, with rug-making her chief occupation. Both became interested in an older-adult club, and have since been faithful and cheerful members.

The social group is a vital tool in assisting older individuals to maintain their feeling of usefulness, status, and belonging. It is a means of remaining a contributing member of society, restoring a person to some degree of capacity, to full restoration of social capabilities, and it has a direct bearing on the medical and psychiatric expenditures for older people. It is a resource whose possibilities should be utilized to the full. With the coöperation of individuals, organizations, and the community as a whole, social rehabilitation and social-maintenance opportunities will be immeasureably increased.

A MENTAL-HYGIENE CLINIC IN A PUBLIC-HOUSING PROJECT

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AS an approach to mental-health epidemiology, the Mental Hygiene Section of the Chicago Board of Health, with the coöperation of the Chicago Housing Authority, established a weekly afternoon psychiatric-diagnostic clinic in a low-rent public-housing project in a slum area on Chicago's South Side.

The clinic was set up on June 1, 1952, on the premises of an infant welfare station of the board of health, located in the Ida B. Wells Homes, and was maintained until May 31, 1953.

The assumptions underlying the establishment of the clinic were: (1) that a mental-health problem of large proportion existed in the project, an assumption based on empiric observation of mothers and children in the infant welfare station; (2) that residence in the project insured that basic housing needs would be met, and to a large extent, that cases of extreme financial want would be absent; and (3) that a diagnostic clinic with brief treatment of benign cases and the reference of serious cases could, as an integrated part of the housing-project community, function as a preventive-psychiatry unit, through special emphasis on the mother-child relationship.

The aims of the clinic were as follows: (1) to provide a resource for teaching mental hygiene to the nurses of the Chicago Board of Health; (2) to carry out fact-finding studies related to the specific mental-health needs of tenants of a publicly administered housing community; (3) to provide opportunities for designing, testing, and demonstrating (for educational purposes) procedures adequate to cope with the mental-health needs of such a population.

The Ida B. Wells housing project covers ten acres. It has approximately 7,000 residents, 4,000 of whom are under the age of twenty-one. Some 35 per cent of the residents receive public assistance. The top family income of self-supporting tenants is $4,000 per year (maximum for a family of five or more). Approximately 10 per cent of the project area is devoted to recreational and other community needs.

The children living in the project attend two elementary schools and one high school in the area. It was planned to secure the coöperation of the key personnel of these schools, to enhance the work of the clinic in the direction of a better understanding between school and clinic personnel, and to obtain more timely reference of children who manifested incipient mental-health problems.

No local epidemiological study of the incidence of mental-health problem cases in a housing project has yet been conducted. From data made available by the Baltimore and Tennessee surveys, as given by Felix and Kramer,[1] one could expect a quota of 60-70 per thousand, or for the Ida B. Wells Homes, with its population of approximately 7,000, a quota of from 400 to 500 individuals in need of diagnosis as well as of supportive or intensive therapy.

The general announcement about the organization of the clinic was made through the public-relations service of the housing project. A notice was circulated among the tenants in the form of a flyer which indicated that the clinic was to function "to help in dealing with problems of adjustment at home or in school. Tenants who feel that they or their children may profit from mental-health counseling should call for an appointment. . . " etc.

In addition to the above notice, the monthly magazine of the Chicago Housing Authority carried a note announcing the opening of the clinic.

The diagnostic and reference services of the clinic were available to all residents of the project on a voluntary basis. Some of the clients were recruited when they brought their children to the infant and preschool clinics of the board of health. Members of the mental-hygiene team (psychiatrist,

[1] See "Research in Epidemiology of Mental Illness," by R. H. Felix and Morton Kramer. *Public Health Reports*, Vol. 67, pp. 152–60, February, 1952.

psychologist, and social worker), participating with the pediatrician in general clinic sessions, were often able to detect from observation that an adjustment problem was present. An appointment for the special clinic was then made on a purely voluntary basis. In addition, special notices were sent to all tenants, describing the services available.

In all respects, an attempt was made to treat the clients as if they were patients in a private psychiatric clinic. No home visits were made and no other members of the family were interviewed without the consent of the first registrant.

In cases of children, the patient was usually given (1) an intelligence test (Wechsler intelligence scale for children or Stanford-Binet) and (2) a projective-technique test (children's apperception test); (3) on occasion a reading test or Rorschach test also was given. A social history was taken by the social worker, and the patient finally was interviewed by the psychiatrist, after which a staff meeting was held, and a diagnostic evaluation made, with some decision as to the disposition of the case. Preventive counseling was then given and necessary references and recommendations were made. Although the services offered were primarily diagnostic, in some instances, when it seemed that brief therapy would be beneficial, patients were seen on several occasions.

In order to reach as many as possible of the people living in the project, it was decided to conduct a series of monthly evening meetings, with discussion of mental-health subjects and showing of appropriate motion pictures. A notice was sent to all residents of the project inviting them to view a motion picture on mental health and stating, "*This program is of special interest to parents.*" Thereafter a similar notice was sent before each monthly meeting to those who had been present at earlier meetings.

Nine meetings were held during the year. Twenty-one persons attended the first meeting. The second meeting was designed for adolescents only, and 35 attended. There was then an increase to 27 at the third meeting, and a drop at the fourth, fifth, and sixth meetings, conducted in December, January, and February, to seven, ten, and eleven persons respectively. The drop in the December meeting may have been due to the fact that the weather was very cold. The January

meeting was just after the holidays, which may have influenced the attendance.

When the attendance at the February meeting did not increase substantially, it was decided to make future meetings social as well as educational. Accordingly, notices were sent out prior to the last three meetings, indicating that refreshments would be served, with two hostesses volunteering from the group. As a result, the attendance at the March meeting rose to twenty-seven; but thereafter it dropped at each of the two successive meetings, in spite of the added attraction.

Clinic Activities—Sixty-three cases were referred to the clinic. As stated above, the only publicity given to the clinic was directed to the residents of the project, and they were not very responsive to this approach. It is, therefore, not surprising that the largest number of referred cases (35) came from board-of-health personnel functioning in the infant welfare station. The evening meetings for parents were the next largest source (12). Although the housing personnel seemed interested in the clinic, attended the evening meetings, and mentioned the clinic to the tenants whenever possible, they requested appointments for tenants in only two instances. Also, although a social worker had visited a nearby high school, and had discussed the clinic with adjustment teachers, only two cases were referred by the school. In spite of the publicity given within the project, only six individuals made direct application for advice, and one was referred by a relative and one by a friend.

When appointments were given, an effort was made to get a statement from the source of the reference as to the specific problem involved. In most cases, however, the actual problem was ascertained from the adult involved. The fact that the largest number of referred cases (26) was because of a behavior problem may have been due to the participation of parents in the evening meetings, where problems of thumb-sucking, feeding, bed-wetting, nail-biting, sibling rivalry, etc. were discussed. Also, the nurses and physicians working in the infant welfare stations had been exposed to discussions of these problems and, therefore, were aware of their significance. School problems, represented by 16 of the referred cases, included such difficulties as truancy and reading and

speech defects. Other reasons for reference were worry about pregnancy, marital difficulties, and alcoholism.

Not all of the 63 patients who applied to the clinic were seen by a social worker, a psychologist, and a psychiatrist. Eleven patients failed to keep their initial appointments. Of the remainder, 20 were interviewed by the social worker only, and 15 by the social worker, the psychologist, and the psychiatrist. Still smaller numbers had the benefit of only two of these disciplines.

All cases interviewed were staffed for the purposes of diagnosis and disposition. In 18 of the cases a diagnosis was not made because of insufficient information. The two largest diagnostic groups were those of mental deficiency and adult maladjustment, each numbering 10 cases. The next largest group was that of primary behavior disorders of children, with four cases. Three individuals were classified as psychoneurotic and three as alcoholic.

One of the primary functions of the project was to evaluate the problems presented by the patients and to give direct help or refer to treatment resources. Of the 63 patients who applied to the clinic, 11, as stated above, failed to keep their initial appointments. In the remaining 52, the evaluative study, because of broken appointments, was too incomplete in 16 cases to allow for disposition. This left only 36 patients who could be given help or referred elsewhere. Of these, 16 were referred to treatment resources; in six instances findings were sent to the active social agency, one case was certified for commitment to a state hospital, and in two instances the nurse was advised to help. All of these cases might well be grouped together, since the responsibility for further help was transferred to another resource. Thus it might be said that 25 of the individuals who had a complete evaluative study were referred to other sources. The remaining 11 were given advice directly, indicating that roughly one-third of the problems revealed by careful study could be dealt with by direct advice, guidance, and brief therapy.

CONCLUSIONS

The primary purpose of the mental-hygiene clinic established in the Ida B. Wells housing project was to provide a

stimulus for the development of interest in mental health in the housing community. In so far as this stimulus evoked 63 cases that were referred to the clinic during a period of eleven months, the purpose of the clinic was achieved to a limited extent.

If mental-health problems of large proportion existed in the project, as was our original belief, this was not uncovered by the method of inviting the tenants to bring their problems to the clinic. It seems likely that the announcement of the clinic and the invitations to attend the evening lecture meetings were not worded emphatically enough to motivate the tenants to contemplate their personal problems or seek help for them. Even when they reached the clinic, the majority broke later appointments. In the evening meetings some awareness of problems was evidenced, but the attendance dropped fairly steadily, except for a spurt when a social function was added.

Nevertheless, roughly half of those attending any one of five of the eight meetings for adults returned for subsequent meetings, indicating that participation in group discussions was more effective than written notices. Even so, only twelve of the cases referred to the clinic were recruited from those attending evening meetings and only six other persons living in the project were self-referred, whereas thirty-nine were referred by outside agencies, again demonstrating the poor response of the tenants themselves.

The problems encountered proved to be about equally divided between those that could be dealt with briefly, and those that involved deep-seated conflicts and attitudes which required much more than evaluation and brief therapy.

Whether the clinic functioned as a preventive-psychiatry unit was not learned, as it did not continue long enough to make follow-up studies. It had been started solely as a pilot unit to learn whether the tenants living in the project would utilize it, and was discontinued after the year's experiment. It was then suggested to the housing authority that the clinic be reopened under different auspices if a thorough preliminary fact-finding study indicated the need.

Our experience in the operation of a mental-hygiene clinic in a housing project led to the conclusion that such a clinic

can succeed only after a well-planned educational campaign. This should start with a mailed questionnaire to all residents of the project, which would contain an introductory paragraph explaining the function of the clinic, followed by a series of structured questions to which the tenant is to reply either "yes" or "no," or to check a simple quantitative scale regarding his mental-health needs.

Next, depending on the response to the questionnaire, a program of lectures, films, and "get-togethers" should be planned, for all age levels, to take place on a weekly or bi-weekly basis over a given period of time. Posters, mailed literature, and possibly door-to-door canvassing might be utilized in calling the tenants' attention to the services available. Announcements in local newspapers, at project meetings, and in the infant welfare station in the project should be made.

A series of group sessions might be attempted with a nucleus group, to investigate mental-health needs and responsiveness to a planned program. This would comprise an integrated course in child development from an experimental point of view, in which parents would contribute "data" to the study.

A further attempt could be made to question existing social groups or clubs in the project—such as choral groups, sewing clubs, and hobby groups—regarding mental-health needs.

Finally, the information obtained by the above methods could then be evaluated to determine to what degree the residents of a housing project can be helped to perceive their mental-hygiene problems, and how extensively they may be expected to respond to a mental-hygiene program within the project.

BOOK REVIEWS

KINSEY'S MYTH OF FEMALE SEXUALITY. By Edmund Bergler, M.D., and William S. Kroger, M.D. New York: Grune and Stratton, 1954. 200 p.

This small book (six chapters, two hundred pages) is part of the current general onslaught against the second Kinsey Report. Why there should be so much hostility directed against the second Kinsey volume is an interesting question. The attack may be merited in part because of the deficiencies of the study; in part it may be an expression of the aggressions resulting from our own sexual frustrations. And the prominence of the Kinsey study makes it a highly visible target. There appears to be more feeling about Volume II than there was over the first volume, on the male, perhaps in part because we resent that the veil has been lifted from the intimate life of the female, about whom we like to keep our illusions, and whom we therefore seek to "protect."

The main charge in the volume under review is that Kinsey's approach involves an anti-psychiatric and an anti-medical bias. The bill of particulars is presented in Chapter 1, which carries the title, *Twelve False Premises in Kinsey's Methodology*. Some of these are the following: (1) when questioned, people will tell the truth about their sex life; (2) those who volunteer information about their sex life are normal; (3) sex can be studied without reference to the unconscious; (4) the hedonistic element in sex is not important, especially for women; and (5) whatever is found to be prevalent is normal. The subsequent chapters for the most part elaborate on these premises, which are held to be false.

Some of these allegations may not be without merit. The use of volunteers probably means that Kinsey's sample is loaded with abnormal subjects. Homosexuals, for example, will often talk to ameliorate their sense of guilt, and they may recruit other volunteers to help bias the record in their favor. This may account for the high incidence of abnormality in the Kinsey report.

On the other hand, the key assumption of the book under review—namely, that sexual behavior cannot be profitably studied without reference to its psychological aspects—is not well founded. Each discipline has its own special perspective and is concerned with its own order of phenomena. It is entirely legitimate for Kinsey, a biologist, to conduct a census of orgasms. If the psychological aspects

of orgasm were known, our knowledge would be fuller. But a census of sexual outlets is a contribution in itself.

The book under review is written in a disputatious, argumentative style, not in the restrained, dispassionate manner of science. There are many references to the first Kinsey volume, whereas the book under attack is the second volume. Also, the discussion is repetitious.

A curious set of adversaries, then: Kinsey and his ilk versus the psychological doctors. Kinsey's findings are based on extensive data and careful measurements, with a minimum of psychological interpretation, except where he goes beyond his data and assumes the rôle of the moralist and crusader. The studies of the psychiatrists are rich in interpretation, but meager in measurement and the rigorous testing of hypotheses. Efforts to use quantitative methods in the study of the symbolic aspects of sex have so far not been very successful. Yet, if our hope is that one day we shall have findings that are reliable, these efforts must be continued. Our goal must remain the quantitative study of the symbolic (social-psychological) aspects of sex, using representative samples of the population and hypotheses that can be tested.

M. F. Nimkoff

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Symbolic Wounds: Puberty Rites and the Envious Male. By Bruno Bettelheim. Glencoe, Illinois: The Free Press, 1954. 286 p.

This is a badly organized, repetitious, and oddly fascinating book. In it, Bettelheim has set himself the task of examining genital mutilations and puberty rites with a view to discovering their psychiatric dynamics. In general, his thesis might be stated thus: first, circumcision and other genital mutilations are not so much demanded of children by parents as they are required from parents by children for themselves; and, secondly, they are intended to assimilate the male to the female, out of envy of her procreative functions. The first part is in line with the work of Susan Isaacs and others of the British school of child analysts, tending to show the internal genesis of conflicts and guilt, and as such it is entitled to respectful attention. As for the second part of the thesis, intellectual honesty alone requires that we examine carefully the premises of our male-centered psychologies.

Nevertheless, at whatever peril, the anthropologist is likely to consider the first part more plausible than the second. Why should an ordeal that "makes" a boy a man, an adult member of the society of males, be interpreted as making women of them? Zipporah to the

contrary notwithstanding, women don't initially demand circumcision; men do! And if women do come to require a circumcised male, it is because he is accounted more "manly," not more womanly, a mature male and not a boy. On the whole, both the conscious and the unconscious testimony of natives is to the effect that the purpose of puberty rituals is to *sever* Œdipal ties, to dramatize the boy's moving from the oral-dependent rôle of a child in his family-of-origin to the larger phallocentric society of adolescent males, which may help prepare him for the forming of his own ultimate family-of-procreation. If the symbolism of the ritual is so often that of rebirth, it is because it borrows the symbolism of the only physical blood tie known to primitive men for the creation of a new synthetic social tie—that of blood brotherhood—and not necessarily out of *envy* of women and of their functions. Psychosexually, in fact, this early stage is one in which the boy flees the maternal and the feminine, admiring and even overvaluing the phallic and the masculine, and returning to the female only when the assurance of his own masculinity has been established by the introjection of male values.

Of the available analytic theories, therefore, Marie Bonaparte's is the more probable: that clitoridectomy is to make the woman more feminine, and circumcision to make the man more masculine. Furthermore, is it the purpose (p. 155) to make the priestly castrate more *like* the Great Mother—or is it a guilt-laden avoidance of greater punishment for being an Œdipal male? Again, transvestism seems primarily protective camouflage; not envy of females, but fear of being male. And trophies are clearly to *gain* male mana.

However, in fairness to Bettelheim, it should be stated that (for all his repetition) he is not dogmatic, but entertains these alternative theories also. The analytically sophisticated person, meanwhile, is fully prepared to accept Bettelheim's explanation as part of the "over-determination" of these complex puberty rituals. Nevertheless, the main theme seems to the anthropologist to be this: childbearing is the female mystery that makes blood ties and kinship; initiation is the male mystery that makes societies.

Unfortunately, Bettelheim (p. 164) attacks anthropologists who alone would have evidence to support his thesis; and he criticizes Róheim (pp. 124–126) for a theory that he himself advances. Incidentally, he is unfair to Róheim, for Róheim did do field work in Australia. Some of the space that Bettelheim uses for repetition could well have been used for a richer citation of the plentiful evidence bearing on his subject; in particular, initiation on the Fly River, more circumstantial details on couvade, the Naven ceremonial, and the rich and accessible Melanesian and other material on the

socio-sexual part-disfranchisement of men in marriage in some parts of Oceania.

But whatever its faults, Bettelheim's book is a genuinely valuable contribution to the discussion of an important problem, and it is certain that, for all their strangeness, his interpretations will have to be taken into account in later discussion of the problem.

WESTON LA BARRE

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THE INTERPERSONAL THEORY OF PSYCHIATRY. By Harry Stack Sullivan, edited by Helen Swick Perry and Mary Ladd Gawel, with an introduction by Mabel Blake Cohen. New York: W. W. Norton and Company, 1953. 393 p.

This is a book that is well worth the time required to read it carefully. As is characteristic of Sullivan, his goal of precision and clarity sometimes obfuscates, and he introduces one to a new and unfamiliar terminology, but this has the distinct merit of deleting essentially all of the Freudian terminology which has come to mean such divergent things to various people. To those who have said that Sullivan's theory is merely a watered-down version of Freud's, I can only say I cannot agree. This book presents a new, or at least quite a different, approach to the understanding of human nature from the traditional Freudian one.

By far the most significant part of the book is the one dealing with the developmental epochs, in which the factors in interpersonal relations (in combination with the physical and physiological substratum) which contribute to the development of any person actually come alive and become significant. Sullivan presents the developmental epochs as follows: (1) infancy, from birth to appearance of articulate speech; (2) childhood, from infancy to the appearance of the need for playmates or coöperative beings of approximately one's own level and status; (3) the juvenile era, from childhood through grammar-school years to the eruption due to maturation of a need for an intimate relation with another person like himself; (4) preadolescence, a brief period ordinarily ending with genital sexuality and puberty and the movement of strong interest from one's own to the opposite sex; (5) adolescence (varying from culture to culture), continuing until one has patterned some type of performance that satisfies one's lust or genital drives. Late adolescence, adulthood, and old age are not dealt with as such in the text, since the emphasis is continuously on factors in the *development* of personality or character.

Of a total of 380 pages, 130 are devoted to infancy, which gives a fair estimate of its relative importance in Sullivan's scheme, but he takes pains to state, "I am conspicuously taking exception to the all-too-prevalent idea that things are pretty well fixed in the Jesuitical first seven years." In fact, the dominant and recurrent thesis of Sullivan is that everything pertaining to life and living is dynamic, in movement, changing and being changed. He sees life and people as having innate tendencies toward maturation and wholeness, and at the boundaries of each developmental epoch, the individual is particularly susceptible to helpful or remedial efforts, irrespective of the unfortunate nature of previous experience. In many ways his viewpoint is the most optimistic I have encountered.

Considerable attention is given to his "self-system," as a basis of operation in any individual. Since my own independent conclusions [1] could in many essential respects be superimposed on the conclusions reached by Sullivan, it is natural that I should feel distinct gratification at the wide recognition his contributions have received. He identifies two main sources of anxiety: contact in infancy with an anxious, mothering person, and later disturbance in the self-system.

Sullivan makes one feel the real tensions and stresses and "integrating experiences" that move an individual toward satisfactory living, as well as the "disjunctive experiences" that form the background of disturbed living. This book is a far cry from the usual texts purporting to give an understanding of the development of personality and the roots of distortion and symptomatology. He makes the minute, but important details of life felt with their full significance.

It is clear that Sullivan did not regard his work as completed or his insights as final, but he was fully aware that the point of view he was presenting was an extremely useful tool. My chief objection to the book is that it is not easy to read, and that, therefore, something that is clearly deserving will be read by too few. An understanding of this point of view would be especially useful in teaching medical students. Psychiatry, implemented with a theory of behavior such as this, might not be as spectacular as Freudian theory, but it would come closer to the truth, and could be integrated by wider groups or people instead of serving as a disjunctive experience.

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[1] Presented in a paper in MENTAL HYGIENE (Vol. 36, pp. 227–44, April, 1952)—"The Self Image: A Theory of the Dynamics of Behavior"—and in *Saints, Sinners, and Psychiatry*, published by J. B. Lippincott Company, in 1950.

ERRORS OF PSYCHOTHERAPY. By Sebastian de Grazia. Garden City, New York: Doubleday and Company, 1952. 279 p.

A sociologist with a wide background in political science, psychology, and religion has undertaken the exacting job of analyzing the defects of modern psychotherapy in practice and in theory. The dust jacket on the book assures the reader that De Grazia, writing with "remarkable lucidity," rips the cover (or words of this tenor) from the mysterious body of psychotherapeutic practice.

One may, at the outset, state the conclusion of the author—namely, that psychotherapy and psychotherapists fail to recognize the essentially moral nature of mental illness and hence do not meet their responsibilities to patients. This conscious evasion or eschewing of their moral responsibility seems to be the chief defect of therapists, especially those who have psychoanalytic predilections.

With comprehensive, although spotty, documentation derived from psychotherapeutic and psychoanalytic writings, De Grazia points out that, among these practitioners, a forthright recognition of the moral aspects of neurosis is lacking, even though they wittingly or unconsciously lean upon authority in treating their patients. From the author's discussion of excerpts of outstanding therapists, one gains the impression that, although the presence of guilt in the neurosis is amply understood, it is not perceived as part of a world-wide moral disalignment, susceptible of treatment only by religion.

The book starts with a brief review of psychotherapeutic methods in an historical context. Here is pointed out the efficacy of ancient and primitive therapists (shamans) which compares quite well with the work of modern psychotherapists. The author indicates that both the shamans and the psychotherapists were and are dealing with similar problems—*i.e.*, moral ones. Whilst the former understood that moral problems were involved in illness (taboos, infractions of tribal morality, and so on), the latter have missed the bus. Discussion of the main issue of the book—that neurosis is a moral problem ("neurosis announces the presence of a moral split," p. 40)—is succeeded by discussion of the place of authority in the therapeutic process. This is so deeply imbedded in therapeutic attitudes, tone of voice, and accents that authority becomes the essential tool of the therapist. In this discussion the author does not differentiate too sharply between non-directive (Roger's) technique, psychoanalysis, and expressive and inspirational methods of psychotherapy.

There follows an analysis of the six major theories (catharsis, relief of anxiety, tracing of unconscious motives, and so on) that are involved in modern therapeutic work, tending to show how therapeutic motives are widely divergent.

If the techniques of healing differ among different therapists, then the moral directives emerging from the therapy must also differ. In that case, the author asks, (p. 155) "How can the collative effect of psychotherapy in the community be good?" There must be some common ground for patients to be healed in a way that will allow them to fit into their community.

De Grazia makes the interesting point that mental healing is deeply involved in preparing patients for life in a community. What is a community of men without morality? "Morality embraces all that is alive in the law." This reasoning leads directly to the conclusion that the need for fitting the patient into the community pattern requires the aid of, or even the assumption of, the task by those "responsible for knowledge of the connectedness of things within the community . . . the statesman and the theologian" (p. 218).

From this point of view, the true communities of man's life are the "political and religious communities." Further, the conclusion arises from this viewpoint that psychotherapy must maintain the problems of morality and law as a constant base line as it works with mental illness. This calls for reorientation of the whole attitude of psychotherapists—calls for them to come out of their chambers, with which an aura of mystery is always associated, and face the fact that they know no more and perhaps less than those who have dealt with morality over the ages. The author also examines the influence of religion in healing, finding that it must grow with the times and not become mired in "old incrustations."

Although Dr. Grazia complains that religion is not itself ready to face the moral dilemma in which society is enmeshed, it is toward psychiatry specifically that he aims his advice that religion, which stands for "art and suffering and exultation" of the human spirit, must be admitted to the psychotherapeutic clinic, where the suffering and exultation of human beings are dealt with.

In a final chapter entitled, *The Vision*, De Grazia calls physicians to perceive their community involvement and perhaps, in this new perception, to return to their ancient birthright of religion. This, at least, is what the present reviewer derives from this often witty, provocative, and discursive book. Obviously it is not written from clinical contact with psychotherapy. Because of its wider background, it lumps mental healing and mental illnesses together, a position that is not particularly applicable to the problems the clinical psychotherapist encounters.

Be that as it may, the basic message is that the shortcomings of secular psychotherapy could be solved by attending to the undoubtedly important problem of morality in neurotic symptomatology and to the community needs as viewed by a political scientist.

The book is provocative. However, the theoretical difficulties with psychotherapy require a more careful working through, from a clinical point of view, than is provided in this volume. But to do this would really mean a complete revamping of psychotherapy as a discipline, or perhaps even the formation of a new science of social psychotherapy. Many forward-looking therapists are acutely aware of the need of this evolutionary step. The volume under consideration does not provide the means, or the basis, for any such sweeping rewriting of the field of clinical psychotherapy.

The book deserves readers, however, because of the many broad facets of the field that it illuminates.

WALTER BROMBERG

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PROBLEMS OF INFANCY AND CHILDHOOD. Edited by Milton J. E. Senn, M.D. (Transactions of the Sixth Conference on Problems of Infancy and Childhood of the Josiah Macy Jr. Foundation.) New York: Josiah Macy Jr. Foundation, 1953. 160 p.

In the introduction to this volume, Dr. Frank Fremont Smith, Medical Director of the Josiah Macy Jr. Foundation, points out that the foundation is interested not alone in furthering knowledge about infancy and childhood, but also in promoting meaningful communication among scientific disciplines. He says further: "Thus, our meetings are in contrast to the usual scientific gatherings. They are not designed to present neat solutions to tidy problems, but to elicit provocative discussion of the difficulties which are being encountered in research and practice."

The discussions of the Sixth Conference on Problems of Infancy and Childhood centered around three papers: *Emotional Development in the First Year of Life,* by Sibylle Escalona, of the Child Study Center, Yale University; *Observation of Individual Tendencies in the First Year of Life,* by Katherine M. Wolf, also of the Child Study Center at Yale University; and *Excessive Crying in Infants—A Family Disease,* by Ann Stewart, of the Child Health Center, University of Washington, Seattle.

Dr. Escalona points out at the beginning of her paper that she was asked by Dr. Spock to attempt an infant-centered discussion of early development. She uses as a basis for her paper observations of infants and their mothers made during the time when she was director of the Department of Research of the Menninger Foundation. Dr. Escalona says that her paper is a series of personal experiences. "In part, these experiences are factual and occurred during more hours than I like to count spent in observing babies and their mothers and

in talking with their mothers. In part, the experiences consist of a peculiar conglomeration of impressions, thoughts and fantasies about the observed material which have come to serve as a framework and background for my more systematic attempts to study infant behavior. It should be made clear in advance that this is an irresponsible thing to do."

If Dr. Escalona considers that she has been in some ways irresponsible, she has been to me completely delightful and charming. Her creative fantasies have made her observations of infants and their mothers come to life. Dr. Escalona says, "Nowadays, I tend to think about behavior and development much more literally as a process of interaction between the organism and the environment." Many of the questions that are raised so often in psychiatric and guidance semantics are touched upon here in terms of actual observations of babies. What are some of the different ways babies and mothers behave around the nursing and feeding situation? How does the baby sense the outside world? What are some of the developmental aspects of ego development—the distinction of the self from the non-self?

In a fascinating section of her paper, Dr. Escalona discusses "Social Interaction, Contagion, and Communication." She begins by pointing out that, from his first day onward, the baby is reacted to and himself reacts to other persons. The nature of these contacts—more frequent, varied, and complex, the older he gets—is perhaps the single most important determinant of how he will experience his world and of the kinds of human relationship that he will be able to have as he grows up. She distinguishes between communication between mothers and babies and the more one-sided process that she terms contagion. She discusses the different ways mothers interpret the behavior of their babies and some of the determinants that seem to play a rôle. She says that some mothers seemed to be extraordinarily blind to behavior clues provided by the baby—*e.g.*, the mother who entertains the baby who appears to all observers to be sleepy, or who attempts to feed the baby who is spitting up and showing signs of distress.

Dr. Escalona concludes this section of her paper with more detailed observations of babies in two families, with emphasis upon the subtleties of communication between mother and child. The delicate nuances of Dr. Escalona's observations make these more detailed studies, as well as the entire paper, delightful. It is a paper that should be of deep interest to many different professional people. It should be read, as it is impossible to convey its charm and depth of meaning in any brief review.

Dr. Wolf's paper reports on a small part of a longitudinal research

study at the Child Study Center at Yale, a study that included, at the time the paper was presented, 16 infants and their mothers. Dr. Wolf presented the history of one baby and her mother in some detail; the material included information about the life history both of the mother and of the father obtained before the child's birth, and material on observations of mother and baby.

The members of the conference discussed the various ways of observing infants, some of the problems of training observers, and the variable introduced by the presence of an observer. These comments will be particularly interesting to any one who has attempted research in this complicated field. The members also discussed the question of prediction. What can be predicted regarding a baby's development from what is known regarding the mother's life history, from what is observed in her handling of the baby, and from physical reactions of the baby? This discussion will interest the psychoanalytically oriented reader. In commenting upon the paper, Dr. Ives Hendrick, of the Department of Psychiatry, Harvard Medical School, said: "Your presentation is extremely interesting from many points of view, but especially from the point of view of method. I think we all agree with the fact that we should attempt other kinds of research in addition to those that are based upon reconstruction and interpretation, and this has been an outstanding example of the mechanics of that principle. We need observations of infants and the relation of infant to mother."

Dr. Stewart reports on a study of 12 infants who cried excessively. Again, this paper evaluated the behavior of the infants in relation to their handling by the parents. In addition, certain physiologic entities were observed and tested.

This review should make it clear that this publication will be very interesting and useful to professional people working in the fields of child development and dynamically oriented psychiatry and child guidance.

FRANCES P. SIMSARIAN

Washington, D. C.

THE PSYCHOANALYTIC STUDY OF THE CHILD. Vol. 8. Edited by Ruth S. Eissler and others. New York: International Universities Press, 1953. 412 p.

There is constant affirmation in the volumes of this series of Freud's prophecy that through the field of child analysis further growth will take place. In the present volume—No. 8—the major contributions are centered around early ego-maturation disturbances. Each successive volume of the series has touched newer aspects of early

schizophrenia, and now we have a group of contributors that began with Bender and is reinforced by Annemarie P. Weil. Out of a welter of syndromes, which at first were highly confusing, some order and system are being organized, and those of us who work with children are experiencing some clarification of the perplexities we have struggled with so long.

The keynote of this volume is in Anna Freud's remarks on infant observation. Any medical student—or, for that matter, any professional person working with children—should read this beautifully written article. Simplification here is clarification, and there is no loss in value in spite of the complexity of the information imparted. This is surely a literary model of a type that is all too rare. This paper confirms the reviewer in his repeatedly expressed opinion that those who work with adults should at some time in their professional education be exposed not alone to the so-called normal child's growth, but to its early differentiations.

Another encouraging emphasis will be found in the chapter by Margaret E. Fries and Paul J. Woolf, *Some Hypotheses on the Rôle of the Congenital Activity Type in Personality Development*. One cannot but be impressed with the fact that the question of heredity has been gingerly handled here. The reason why is understandable, but this question should not be overlooked in our therapeutic evaluation when so much depends on the strength of the ego, whose origin is psychosomatic.

Phyllis Greenacre contributes a fascinating paper on fetishism, its genesis, and the divergent concepts of it. She leans to the concept of a preceding weakness at the phallic phase in the pre-genital structure, with a rift in the early ego development.

The erudite metapsychology of Heinz Hartmann and K. R. Eissler will be found in the section on "Ego Pathology." An interesting point of Hartmann's is that the fragmentation of ego functions is a diverse one, for some intellectual functions may be preserved. In some psychoses certain parts tend to be unimpaired. Eissler believes that some defense mechanisms are genetically congealed emotions, and that rationalization helps the ego maintain not only repression, but the ego's cohesion; it has a synthetic and ego-syntonic function. Ego processes are worked with here rather than id processes, which are postponed.

In the section on "Clinical Problems," we have the usual excellent articles on technique by Bornstein, Alpert, and Kut. *Treatment of a Child with Severe Ego Restriction in a Therapeutic Nursery*, by August Alpert and Sylvia Krown, could really come under the heading of "Applied Psychoanalysis."

The syndrome on "Applied Psychoanalysis" provokes an unusual question—whether the interpretation of autobiographies and fairy tales is not so much an evaluation of the culture that gives rise to them as it is a revelation of the interpreter—and how this would vary with the interpreter.

Running his eye over the various articles, which number twenty-two, the reviewer is completely stumped as to how to do justice to any single article, when each is worthy of detailed attention. They are of such a uniform standard of excellence that to stress one is hardly fair to the others. In our previous reviews we have mentioned the unique contribution of this series of publications. We can repeat that statement here with emphasis.

EDWARD LISS

New York City

CASE STUDIES IN CHILDHOOD EMOTIONAL DISABILITIES. Vol. I. Edited by George E. Gardner, M.D. New York: American Orthopsychiatric Association, 1953. 368 p.

This book, a collection of thirteen cases presented in workshops at meetings of the Orthopsychiatric Association in 1950, '51, and '52, is an important addition to the literature. Most of the case studies are so well written that the summaries give a surprisingly clear picture of the therapy and case-work. The theoretical formulations of the dynamics of the cases are in general equally well stated. Moreover, such a variety of problems are represented that even an experienced therapist should learn something from some of the cases, as well as finding the material useful for teaching.

The two case reports of children treated at the James Jackson Putnam Children's Center in Boston might well be read one after the other (although not given in this order in the book) because they discuss some of the criteria for differential diagnosis between so-called atypical or autistic children and those who may be extremely disturbed, but not actually schizophrenic. The description of the treatment in these two cases indicates some of the differences in therapeutic techniques suitable to each child's emotional problems. The first of these cases was presented by Beata Rank and Samuel Kaplan, under the title, *A Case of Pseudoschizophrenia in a Child* (pp. 1-27). The second was described by Eleanor Pavenstedt and Irene Anderson in the paper, *Complementary Treatment of Mother and Child with Atypical Development* (pp. 201-235).

There are two papers that deal with severe psychosomatic symptoms: *Adolescent Alternation of Anorexia and Obesity,* by Berlin, Boatman, Sheimo, and Szurek (pp. 45–77), and *Psychogenic Diarrhea*

and Phobia in a Six-and-a-Half-Year-Old Girl, by Melitta Sperling (pp. 236-246). For those of us who are accustomed to working with patients in a clinic, the case of the adolescent girl will be particularly interesting because of the long period of hospitalization during which she was treated; moveover, an excellent bibliography of writings on obesity and anorexia nervosa is given. However, the report reads less smoothly than most of the others because discussions of the emotional problems of the persons working with the girl and her parents are alternated with descriptions of the treatment. Melitta Sperling's presentation of her material is a contrast in style. It is written lucidly, briefly, and to the point.

Some of the papers deal with situations that often arise in clinical practice. Curtis and Capron (pp. 78-103) suggest one technique that may be useful in dealing with adolescents who are resistive to therapy when first introduced to it at the behest of parents. It is sometimes possible for these adolescents to return later of their own volition, after having had a few interviews in which they learn what psychotherapy is like and then being permitted to stop. Another common kind of resistance appears in Blom's adolescent boy, who was delinquent, came under court pressure, and terminated his therapy as soon as he was off probation (pp. 178-200). Another practical matter is discussed by Dr. Newell—the necessity for experimenting with short periods of therapy imposed by such a large number of referred cases that it is impossible to provide long-time therapy and still meet community demands. (pp. 247-264).

Treatment in a residential setting is described in two cases: one a nine-year-old girl with petit-mal epilepsy who also was overaggressive and enuretic (Krug and Hayward, pp. 155–177); the other, a ten-year-old boy whose behavior was extremely destructive (Wise, Krug, Hayward, Crumpacker, and Graham, pp. 331-368).

Six-year-old Artie, "victim of an inconsistent parental relationship," (pp. 104-154) and nine-year-old Lewis, illegitimate, who spent his first four years in a foster home, then was taken by his grandparents (pp. 265-306), represent the kinds of situation in which children often develop problems that bring them to child-guidance clinics. Dr. Tulchin's discussion of the treatment methods employed with Artie should be read carefully, for the questions he raises certainly are legitimate ones.

Dr. Buxbaum's case (pp. 28-44) is focused on the latency period of childhood, which, as she mentions, has been less well explored psychoanalytically than the pre-latency period or adolescence.

Perhaps the most unusual case of all is Dr. Lippman's adolescent boy whose conscious wish to become a successful criminal was based

on unconscious neurotic conflicts (pp. 307-330). It is as enthralling, reading as any suspense novel, for we cannot foresee the outcome, and we do not know until the end whether the boy will persist in his determination to embark on a criminal career or not. The therapy in this case is a beautiful piece of work, for which Dr. Lippman should be given full credit.

After finishing this book, one will be likely to ask eagerly when Volume II may be expected—and to hope that the next series of cases will be as valuable as those in Volume I.

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CHILDREN ARE ARTISTS. By Daniel M. Mendelowitz. Stanford, California: Stanford University Press, 1953. 140 p.

The artistic spirit is frequently set over against the exactness of the scientific method and orientation. It is not surprising, therefore, that artists who write about the art education of children sometimes exhibit quite different conclusions about procedures, methods, and results. The volume reviewed here belongs to a fairly large group of writings that stress the inherent artistic capacities of all children and that deny that any one technique or method is necessary to bring out the artistic qualities of children. Professor Mendelowitz' opinion is that there is sufficient natural interest in artistic production among young children, so that only a little encouragement and approval is needed to bring out the most satisfying and pleasing results.

Indeed, Professor Mendelowitz insists that "talent" is the result of greater-than-usual practice. He denies that there is any intrinsic or special capacity that can be called artistic ability. Increased activity creates above average performance, by the familiar laws of learning by which skill is increased. This "talent cycle" is believed to operate in all areas of experience, and talent is equated to higher-than-average achievement.

While the book lays particular stress upon the graphic arts, a good deal of material on work with plastic materials, wood, metals, stencil designs, and many other crafts appears. A great many specific suggestions are offered as to how children's interest may be maintained, and some useful bibliographical references are given as well as lists of sources of materials and supplies. The book will be useful to parents as well as to teachers. The reader should not be misled by the illustrations, however, which generally portray work quite superior to, rather than representative of, the work of the age groups indicated. Quite naturally, an artist would be more likely to have access to "talented" children than to unpracticed children.

Throughout his book Professor Mendelowitz stresses the importance of kinesthetic and motor activities to children and their significance in creating the concepts from which children can paint, draw, and model. He suggests that children should be encouraged to have sensory, motor, and kinesthetic experiences, to discuss and comment on these experiences, and then to reproduce them with paint or other media.

He points out that "design activities" pervade the young child's life and play, and that many of these activities can very readily be woven into a course of development that will make later artistic growth pleasant and sure.

He considers in detail what many workers in this field have recognized—that after eight or nine years of age children get progressively less pleasure and satisfaction out of artistic activity, and become more and more painfully self-conscious and self-critical of their artistic endeavors. The solution offered is to give children at this age some instruction in technique, to aid them in solving basic problems of perspective and representation. Professor Mendelowitz insists that whatever will maintain motivation will get children over this period of self-consciousness and criticism.

Other workers have interpreted this situation somewhat differently. Some hold that the increased awareness of the body that comes in later childhood and at puberty makes the child much less willing to draw and paint the human figure; hence the young adolescent's interest in caricature or cartooning and in depicting the head only. Still others hold that the increasing level of the child's mental capacity brings him squarely up against the problem of artistic depiction in a world that stresses visual realism. He literally means what he says when he resists the suggestion to draw with the remark, "But I can't draw—I'm no good at painting. I can't make it look like anything."

While Professor Mendelowitz has little to say about theories of artistic expression, he does emphasize that children should be discouraged from holding the ideal of photographic realism. Such emphasis, of course, is an attempt to counteract the stress on visual realism which our culture lays upon children, as has been so clearly pointed out by Lowenfeld, Shafer-Simmern, and other writers on child art.

Professor Mendelowitz suggests that a child's personality characteristics may determine what medium is most suitable for his artistic expression. He believes that personality characteristics determine the scheme or symbol that the child adopts as his most characteristic expression. While much recent writing emphasizes the "projective" or personality significance of art products, this area has yet to be explored by carefully designed and controlled research studies.

Such studies of children's artistic productions as do exist stress the

gradual change from age to age and the great variety in expression that children adopt at any age. For convenience, Professor Mendelowitz defines several qualitatively different stages in drawing and painting, from scribbling through the search for a symbol (preschool period) to the location of a system or schema (between six and nine). This stage is followed by the analysis of the symbol (between nine and twelve), which in turn is followed by emphasis on the delineation of parts and emphasis on the physical world as opposed to the human figure (adolescence).

This reviewer noted with considerable interest the fact that Professor Mendelowitz believes children may learn "good taste" from exposure to "poor quality" material, such as cartoons. This point of view, so contrary to what many parents believe, is nevertheless in accord with some research material on the development of esthetic discrimination.

Those interested in the significance of art for mental hygiene will be particularly pleased by Professor Mendelowitz' insistence upon the need for self-expression and creativity in the modern complex and stereotyped world. His concluding chapter is brief, but emphatic upon this point and encourages us to follow our desire to do things with our hands—to be creative, and to find the means for self-expression in order to break with the standardization of objects, tastes, ideas, and behavior so prevalent to-day.

DALE B. HARRIS

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University of Minnesota

THE MENTALLY RETARDED CHILD. A GUIDE FOR PARENTS. By Abraham Levinson, with an Introduction by Pearl S. Buck. New York: The John Day Company, 1952. 190 p.

Until very recently, no group of parents has been more neglected by the medical profession, and by everybody else, than those struggling with the problem of their offsprings' mental retardation. Aside from the perplexities arising from diagnostic and prognostic uncertainties, they have suffered from the fact that there were few people to whom they could turn in their quandaries who would understand and alleviate their emotional involvements, and who had the information, patience, and desire to dispel widespread confusions. Levinson's book is intended to provide such information and guidance "in terms that the lay reader can understand," to quote from Pearl Buck's introduction.

Much material is covered in the 148 pages of text. Eighteen chapters provide an orientation on psychological testing, terminology,

diagnostic procedures, etiologic factors, treatment, education, vocational guidance, community responsibilities, and research.

In Chapter 17, the author gives a selected list of questions that have come to him "through the mail, on the lecture platform, in the clinic, and at the office." The answers are brief, simply stated, sometimes—so it seems—intentionally oversimplified in order to avoid confusing the reader. In fact, "confusion" is the first issue spoken of in the first chapter, *The Parents and the Mentally Retarded Child.* The subheadings of this chapter give a good idea of the author's awareness of the existing problems: "Confusion," "Shock," "Refusal to Accept Verdict," "Shame," "Guilt Complex," "Bitterness and Envy," "Over-protection and Rejection," and "Adjustments."

The "ten commandments for parents" are admirable; they should be heeded by physicians and teachers as well. The appended list of public and private residential schools is of considerable practical help. The selected bibliography, however, reflects the author's preferences rather than the layman's needs. Myerson's beautiful autobiography and Plant's thought-provoking *The Envelope* are superb, yet hardly adapted to the specific issue; on the other hand, one misses a reference to Sarason's book on the psychological aspects of mental retardation.

On the whole, the book is a successful pioneering attempt at serving as "a guide for parents." It is lucid, informative, sincere, sympathetic, and should be read not only by parents, but also by all those who have a professional interest in mentally retarded children.

LEO KANNER

Harriet Lane Home for Children,
Johns Hopkins Hospital

HOW TO LIVE WITH YOUR TEEN-AGER. By Dorothy W. Baruch. New York: McGraw-Hill, 1953. 261 p.

This short, readable volume is of unique value both to parents and to teachers who want to understand, to help, and to enjoy the teen-agers in their homes or classrooms. Dr. Baruch, with her penetrating insight and rich psychological background, throws adolescent complexities into a perspective that gives them fresh meaning. In addition to highly valuable discussions of the more obvious problems, she shows how childhood phantasies, often still disturbingly present in teen-age feelings and attitudes, may be aired and dissolved.

The discussion of "sex education" is especially helpful, since it deals with worries, feelings, longings, and impulses with helpful frankness and sensitivity to the many realistic problems they generate. Her detailed descriptions, with illustrations from real life of really

thorough thrashing out of all of these problems, are of particular value. Her optimistic conclusions about the wholesome results when teen-agers are helped where they really live in these matters, will reassure the most anxious.

There are particularly valuable chapters regarding the special problems of children of divorced parents and of those who have adopted parents. As Dr. Baruch points out, new wonderings are apt to come into children's minds, as puberty gives new understanding, as to what really happened between divorced parents, or, in the case of adopted children, as to who their own parents really were. Very valuable suggestions are made about helpful ways of discussing both of these questions; also, regarding the importance to divorced parents—and indeed of all who have reached middle-age—of leading rich and meaningful lives of their own, so that they will not be tempted to drain their teen-agers to meet their own needs.

Finally, there are useful, concrete suggestions as to how materials of first importance with regard to teen-agers' adjustments *as persons* may be brought into high-school curricula, including the use of nursery schools to study human interaction and as a basis of deeper self-understanding. It is pointed out that one of the best ways for parents, especially mothers, to avoid middle-age "doldrums" is to busy themselves with encouraging schools to provide more of the functional learnings teen-agers so deeply need in their quest for maturing selfhood.

There is much concern nowadays over the spread of delinquency. It is this reviewer's belief that there could be no surer way of reducing it than for parents and teachers to assimilate and apply the teachings in this book. It is a worthy and much needed sequel to Dr. Baruch's epoch-making earlier volume, *New Ways in Discipline.*

KATHARINE WHITESIDE-TAYLOR
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FUTURE CITIZENS ALL. By Gordon W. Blackwell and Raymond F. Gould. Chicago: American Public Welfare Association, 1952. 181 p.

What happens to children in families that receive money and other services from public-welfare departments? What is the level of social adjustment of children, adolescents, and adults who for more than six months of their growing-up years have been included in Aid to Dependent Children (A. D. C.) budgets? How can the families be described prior to, during, and at the termination of their receipt of such aid?

Answers to these questions appear in this exciting report on a primarily descriptive study, unique for its nation-wide coverage, its longitudinal approach, and its disciplined efforts to analyze causal relationships in a complex field. In 1952, one and one-half million American children were in families being subsidized by A. D. C. The absence or incapacity of a parent requires the use of some financial resource if the children are to remain adequately cared for in their own home. In the approximately fifteen years between the inception of A. D. C. and the start of the Blackwell-Gould study, they estimate that six million children received A. D. C. help. These are, as the title indicates, future citizens all, in a culture that still values the worth of each individual and in a society that needs to develop the quality of all its human resources. What are the indications of potentiality for good citizenship among children—some now adults—who were former A. D. C. recipients? Are the opponents of federal-social-security programs correct in their speculations as to the negative effects of "hand-outs"?

Carried on at the Institute for Research in Social Science at the University of North Carolina, under a grant from the Field Foundation, this study is a rational answer to all those who would continue to argue from impressions and unsystematically gathered facts about welfare services. As social scientists, the writers express appreciation to their sponsors for "the opportunity to make the study" and the "freedom to publish our findings as we saw them." In a preliminary summary statement, which omits discussion of the problems they faced (described in an appendix), their survey procedure is outlined as follows:

> "The method in this study has been to secure, with the coöperation of the public welfare departments of 38 States, the District of Columbia, and the Territory of Alaska, extensive information regarding more than 6,500 families for whom ADC payments were terminated in the fall of 1950 or early in 1951. These families included nearly 19,000 children who were in these homes at some time while ADC was being received . . . it is assumed that our findings are generally representative of the situation of all ADC families at the time of closing in the late 1940's and early 1950's."

The report moves quickly into facts, interpretations of them, and hypotheses for further study. Chapters describe the A. D. C. program as a whole, the characteristics of families at the time of the crisis situations that brought them to seek A. D. C. assistance, and subsequent conditions in these families in regard, for example, to income, housing, and the rôle of the homemaker—a pivotal position in A. D. C. programs. Evaluations and causal analyses are made from data on the educational progress of the children and such other

indices of their adjustment as health and the incidence of delinquency, organized group membership, and school awards. A final chapter discusses the economic adjustment, marital status, and legal violations of A. D. C. "graduates."

As this report starts, appropriately for the too-busy reader, with a nine-page summary of findings (and each chapter ends with a series of itemized summary statements, as well), so the book ends by addressing itself to the less time-pressed and more curious reader in a quite detailed twenty-five-page appendix on the design of the study, the questionnaire sent to state departments of social welfare, and an exact filled-in copy of the interviewers' schedule used with each of the families under study.

The reviewer of mystery books who tells "who done it" earns the opprobrium he receives. This reviewer believes his task complete in having revealed something of the questions, the methods, and the outline of findings fully presented in the Blackwell-Gould report itself. To isolate and quote findings on, for example, educational achievement or delinquencies among A. D. C. recipients would be to spoil the story. The American Public Welfare Association (1313 East Sixtieth Street, Chicago 37) should have, at two dollars a copy, a best-seller in *Future Citizens All.* Reading this clearly written book is an eye-opening experience for all citizens.

HENRY S. MAAS

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Berkeley

CLINICAL APPLICATIONS OF RECREATIONAL THERAPY. By John Eisele Davis. Springfield, Illinois: Charles C Thomas, Publisher, 1952. 126 p.

Every physician knows that people feel better when their time is occupied. They feel still better when they are doing something useful, and they feel best when they are doing things they like to do. From this observation arose the concept of recreational therapy, which began to be applied clinically and officially by the American Psychiatric Association as early as 1913. But in those days such efforts were random and miscellaneous.

In the last forty years the whole concept of recreational therapy has developed greatly, and was enormously stimulated by inventive psychiatrists in military hospitals during World War II, although it had its beginnings in state hospitals long before that.

John Eisele Davis, Sc.D., Chief of Corrective Therapy for The Veterans Administration, has in this book outlined very adequately the clinical applications of this form of treatment. It is a slim book,

but very compact and very well organized. It is divided into 46 brief parts, each one giving specifically helpful suggestions and directions for particular types of patient. It is very condensed, but it is capable of expansion, depending upon the imagination and the resources of the individual therapist. It will serve as a milestone on the road toward further improvement in this important department of treatment. It assumes that the treatment program is actually a matter of teamwork, but it does not neglect individual features that point toward deeper therapies. Especially interesting are the sections on Psycho-Dram (19 and 20) and the use of art, particularly painting, in psychiatric treatment. In view of the adoption of art forms for relaxation by Churchill and other noted public leaders, the reader will find much timely and stimulating interest in this beautifully published book.

MERRILL MOORE

Boston, Massachusetts

MUSIC THERAPY. Edited by Edward Podolsky, M.D. New York: Philosophical Library, 1954. 335 p.

This book consists of thirty-two articles on music therapy by physicians, psychologists, and musicians, some of them well known in their fields. It would be helpful to know when and where these articles first appeared, for it is evident that most, if not all, of them are reprinted from the periodicals that are listed in the front of the book.

The introduction by Dr. Podolsky is largely anecdotal, telling of the remarkable effects of the use of music through the ages in influencing human behavior, mainly in cases of mental illness. One almost gets the feeling that here is a wonder drug: find the right tune and the mental or emotional trouble will disappear. Fortunately most of the articles that follow do not promise anything so rash.

There are several excellent papers, such as that by Mary Jane Preston and that by Hermina Eisele Brown, outlining the organization and operation of a comprehensive program of music in state mental institutions; two papers describing the use of music with electroshock therapy at The Sheppard and Enoch Pratt Hospital; a fine description by several doctors at Duke Hospital of ways to utilize music to advantage in connection with surgery; and an account of a well-controlled experiment on the effect of music on the activity of apathetic schizophrenics, by two men from the University of New Hampshire.

Other articles that are more open to question tell of the value of music in treating specific conditions, such as anxiety states, depres-

sion, emotional fatigue, psychosomatic gastric disorders, and so on. They go so far as to submit lists of compositions "suitable for chronic hatred or hatred that has reached full blossom," and "of value in moderating headaches due to accumulating tensions." Incidentally the musical references should have been checked more carefully. Some are too vague, such as "Excerpt from Sonata for Piano by Beethoven"; others, naming a whole oratorio or opera, are too general. Misprints are numerous, including such gems as "Britten, Ceremony of Carrots" and "Debossy, La Demoiselle Bleu."

More specialized papers include a thorough and painstaking account of the effect of various sound stimuli in controlling athetotic tremors in a single victim of cerebral palsy; an inquiry into the physiological basis of musical experience; and a description of high-fidelity sound-reproducing devices.

A cautious note by Licht is quoted: "To assume that all listeners [to selected compositions] will react in similar fashion or that the moods of the mentally deranged can be changed at will by prescribed music is to ignore the nature of mental disease and the scientific findings of psychologists." Dr. Pepinsky warns us in the final article that "far too many reports of research contain sweeping statements in the evaluation and interpretation of their findings," a warning that should have been heeded by several of the writers in this volume.

The book as a whole does not set out to present one point of view, but gives a cross section of current thought on music therapy, representing all shades of opinion.

ROBERT LEE MILLS

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GROUP WORK WITH THE AGED. By Susan H. Kubie and Gertrude Landau. New York: International Universities Press, Inc., 1953. 214 p.

This is a lively and practical account of pioneer work with the aged as experienced at the William Hodson Community Center in New York City. The authors note several of their reasons for describing their experiences at this day center. Their personal reason was the promise of objectifying an experience that, through nine years of operation, had been daily, continuous, and unendingly varied. There was the realization that the experience was new and in some ways unique, and was, therefore, shaped by circumstances that would not be duplicated again.

The fourteen chapters are devoted to progress from the beginnings of the project, through the development of self-government and pro-

graming, to discussions of terminal years and counseling. Step by step, various problems are discussed, with their positive management in stimulating growth of individual and group morale. The staff members saw a demonstration that old people react in the same way to gratifications, frustrations, to needs and opportunities for social adjustment, as do all human beings at any age. The rôles of many individual clients are high-lighted in considerable detail to show the thread of relationships between members themselves and toward members of the staff in the developing background of the meaning and usefulness of the center.

All but a few of the men and women from varied cultural groups had been referred from the department of welfare and were receiving old-age pensions. A few had independent incomes. The average age was seventy-two years, with a range of from sixty to eighty years. Their development into a cohesive group was gradual and beset by many difficulties. From an initial rather doubtful, unbelieving attitude, responsiveness and initiative quickly resulted with new opportunities and the guidance of the staff. The clients discovered in themselves abilities and interests that grew and developed. Many suggestions for planning a schedule were forthcoming when the aging persons recognized that the opportunity for self-expression was a reality. Stimulating group consideration and action were taken on all plans suggested. Groups for the discussion of current events, for woodwork and painting, for music, dramatics, and poetry evolved. Special affairs, such as birthday parties, were meaningful for individual self-expression and group unity. A center publication interested many.

With the development of leaders in the group and the assurance that membership, instead of staff, set the tone, the staff gradually came to function behind the scenes. Some tact was necessary to lead the group to accept the fact that it should be tolerant of occasional members whose behavior might be somewhat silly, though inoffensive. Discipline by being debarred from the center for a week was necessary only once, in the case of a woman whose persistent querulousness made it appropriate.

A chapter is devoted to relatively non-participating members. Some liked special events and others came just to see their friends. However inactive they appeared, the center supplied the passive members with a variety of stimulations to which to react to counter their own seeming lack of interest.

In the chapter on terminal years, the relative lack of incapacitating memory defects and inadequate behavior was remarkable. In more than 1,000 persons whose terminal histories were known, with slow enfeeblement, admission to old-age homes, a few pronounced senile

deteriorations, and rare psychotic breakdowns, it was apparent that the majority died of a sudden illness before they deteriorated markedly or became too infirm to visit the day center. It was as if the social environment stimulated and sustained their social adaptation even if a closer examination of their faculties might have revealed damage.

This informative and fascinating volume is highly recommended as a source book of experience in group work with the aged.

HOLLIS E. CLOW

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LIVING YOUR LATER YEARS. By Kenneth Walker. New York: Oxford University Press, 1954. 196 p.

This is an interesting and challenging publication. Its title seems to suggest that it was intended for a popular audience. However, it is questionable whether such a group will be attracted to it, for it contains information that at times is more theoretical—and that may also be more historic in its perspective—than some readers may like.

As a review of certain statements of facts and misconceptions about older people and the aging process, the book has great merit. Some of the erroneous beliefs that Dr. Walker clarifies have to do with the possibilities of rejuvenating the body and categorizing the temperaments of old age. The author indicates that efforts at rejuvenation have not been successful and at the present time offer no ready solution to the problems of this age group. He also points out that age does not create new habits, but merely deepens old ones; consequently, aging people behave very much the way they always have.

The positive attitudes that are stressed by the author—and of which we all should be conscious in our thoughts regarding this period of life—include the values of permitting a realistically independent existence for every one, regardless of age, and recognizing the merits of the experience and skills of older people.

The hopeful style in which Dr. Walker writes, in addition to the encouraging statements that he makes, offer assurance to the reader who either is in his later years or is preparing for a happy old age. The book represents an additional contribution to the growing literature in the field of geriatrics.

EDWARD LINZER

The National Association for Mental Health

RECREATION FOR THE AGING. By Arthur Williams. New York: Association Press, 1953. 192 p.

EFFECTIVE USE OF OLDER WORKERS. By Elizabeth Llewellyn Breckinridge. Chicago: Wilcox and Fillett, 1953. 224 p.

These books may profitably be read conjointly. In both, there is implicit and expressed recognition of man's need, as he ages, to remain in realistic, dignified, productive relationship to his chief environment —man—and of the fact that only in this way can he live to the end of his days with pleasure. In both books there is also recognition that with aging there occur frustrations and deprivations that may be beyond individual control, to pose, not a problem of the aged for society, but rather personal problems for millions of individuals.

In our tradition these problems of the aging are our social responsibility. For those who both acknowledge this responsibility and are engaged in some degree in making and preserving opportunities for fuller realization of the potentialities of older persons, these books are useful guides.

The first provides a framework as well as copious detail for the organization and development of social and recreational activities for aging persons. The discussion reveals adequate understanding of the psychological and emotional problems that may be encountered and is well documented with examples of successful groups and workable plans. In detail, it is adequate for its use as a preliminary handbook.

The second book is also well documented and contains considerable factual information relative to flexible plans for the employment or reallocation of aging workers in industry and business. As its title indicates, it is an evaluation of company planning for effective utilization of older workers, and it places emphasis on realistic productivity from the company's point of view, as well as on maintenance of morale and pride in the worker which will reflect credit upon the employer group.

In reading this book, one may be occasionally disturbed by the thought that in an economy in which workers are more numerous than jobs, the social responsibility of employers may tend to decrease. One may expect, however, that such responsibility cannot easily be ignored, because of the increasing numbers of the aging and their consequent importance socially, economically, and politically. In these large social maneuvers, even as in smaller matters, we must have some faith in the good that enlightened self-interest guarantees; such self-interest is a preventive of exploitation.

There is ample evidence in this book that the older worker need not be discriminated against for reasons of safety, reliability, skill, or stamina. The older worker is, in fact, often superior to the younger

one in many jobs, and when properly placed, does not overload the sick, compensation, or pension lists. In many jobs the older worker is to be preferred—a truth so obvious that it may be forgotten, but one that requires planning, the expense of which may seem frightening, but which virtually tends to pay for itself many times over.

In the book on recreation, the importance of meaningful activity, real productivity, the avoidance of artificial situations and of patronizing attitudes toward the participants are stressed. The book on work emphasizes these same factors (and we are promised in the near future a companion volume which will deal more completely with the meaning of work), thus warning us away from an old-style, charity-welfare attitude which can only provoke resentments and loss of self-respect in the worker. These studies, therefore, tend to agree with the psychiatric opinion that mental health is best guarded by the provision of opportunity for realistic mastery of problems and the consequent maintenance or development of self-esteem.

In consideration of the provision of recreational opportunities for the aging and the effective use of older workers, the authors are aware that social workers, psychologists, doctors, nurses, employers, and other specially trained persons must function as a team, coöperating, as the specific individual's problem may require, to provide the optimal framework within which that individual may begin to solve the problem and progress to a functional state that will require a minimum of supportive care.

ALVIN I. GOLDFARB

New York City

THE JUVENILE OFFENDER: PERSPECTIVE AND READINGS. By Clyde B. Vedder, Ph.D. New York: Doubleday and Company, 1954. 502 p.

As a fairly faithful reader of *Focus* and *Federal Probation*, I was delighted to see many old friends in more permanent form in this volume. Dr. Vedder has taken out of the professional journals concerned with the problems of probation and parole and other phases of delinquent behavior articles that he feels should be readily accessible to the student. The book is not a textbook. Rather, as Professor Teeters suggests in his introduction, it is designed to supplement textbooks, of which there are a great variety.

The articles that have been reprinted are the productions of specialists, addressed to men and women whose interest is equally professional. As is well pointed out in the book, the field of youthful delinquency is one in which all sorts and conditions of prophets can cry their wares and be sure of some kind of audience. Dr. Teeters

well puts it that there are authorities and "authorities." The field is still new and knowledge is fluid. Perhaps we shall never reach the point in the study of human nature and conduct where the behavior of human beings can be predicted with grim accuracy. If such a day comes, this reviewer prefers to be put out to pasture.

Concern for young offenders is as old as time. It used to be the fashion to deal with boys and girls in trouble by liberal applications of physical force and harshness. Those who may remember *Knock on Any Door* have before them a vivid and not altogether inaccurate picture of man's inhumanity to those whom it judges worthy of punishment. In the readings that Dr. Vedder places before us, he gives us what those who are in a position to know think a more excellent way of dealing with delinquency.

Thus we are given brief monographs on the meaning of delinquency, the nature and cause of delinquency, and its extent. The book goes on to present readings in economic conditions and familial factors, community institutions, and special personality and behavior problems. A chapter is devoted to the juvenile gang. Apprehension and detention are considered, as are the juvenile court and its development and trends, and probation and the correctional institution; from which we naturally pass on to the problem of parole. The book ends, as it properly should, with a discussion of community responsibility.

To list all who have contributed toward the making of the book would be to set forth the familiar names of those who are constructing the body of our knowledge of the young offender. Of this list it would be impossible to make a selection of particularly impressive articles, although in a work of this sort a certain amount of unevenness is naturally to be expected.

Perhaps as good a suggestion as any as to "what we are up against" comes from the pen of Elizabeth Glover, sometime deputy principal probation officer for London, who says in her article, *Probation: The Art of Introducing the Probationer to a Better Way of Life:*

> "It was assumed that the more decent type of offender would naturally realize that he had merited punishment and be deeply moved by penitence and gratitude if, instead of this, society gave him a chance to make amends. But we now question this assumption on several grounds. First, offenders cannot be classed into black and white. They, like every one else, are a mixture of good and bad qualities. They can be generous and unreliable, loyal and unscrupulous, competent and self-seeking, well-intentioned and impulsive, at one and the same time, making them admirable people in some respects, unsatisfactory in others. Secondly, offenders are not commonly humble enough to admit that they have merited the condemnation of public opinion. Few of us are, when we meet criticism. They are more likely to think that

> they have just had the bad luck to be found out, and so to be moved by self-pity or self-justification rather than by penitence or gratitude. And thirdly, is is really so easy to change one's nature overnight, by an act of will? Can an irresponsible, neurotic, or egotistical person become suddenly reliable, stable, or altruistic by deciding that it would be a good thing if he did? Human nature is not as simple as this. We can only respond to the present situation with our present mental and emotional apparatus."

Here, one thinks, is the heart of the matter. The work of those whose facts and opinions are brought together by Dr. Vedder for us to study are fragments in a mosaic. It is altogether too easy to put a name on a type of behavior and call it delinquent. Society is more apt to have less interest in the etiology thereof than to wonder what can be done. The men and women whose contributions to the study of juvenile offenders are included in this volume are helping us understand its causes and conditions, so that we may be intelligent about the matter. What they have to say is well worth hearing. But heeding is another matter.

The book is eminently worth while.

ALFRED A. GROSS

The George W. Henry Foundation,
New York City

MATERNAL DEPENDENCY AND SCHIZOPHRENIA. By Joseph Abrahams and Edith Varon. New York: International Universities Press, 1953. 240 p.

Dr. Abrahams, who is already well known as a pioneer in the treatment of psychotic patients through the use of group psychotherapy, has once again explored a previously untouched area in the group treatment of chronic schizophrenics. His ability to maintain in a group setting the mothers of chronic schizophrenics in a constant therapeutic relationship with their sick daughters, is a further example of his own dynamic personality. The book is replete with case material occurring in the interaction between mothers and their psychotic daughters. The question of morbid dependency in the chronic schizophrenic is quite vividly demonstrated and the protean reactions of the various mothers toward their daughters is very interesting.

One who is familiar with chronic schizophrenics and has had rather intimate contact with their relatives, particularly mothers, will find nothing new in the various dynamics that are brought out in the group situation. It is the courage and skill of Dr. Abrahams in holding together a group of this type intact throughout prolonged therapy that stands out as an original contribution. Considering

the difficulty of conducting a group of this type and in view of its pioneering endeavor, any criticism of its structure should be accordingly modified.

In reading this book the overabundance of case material weighs heavily on the reader and one becomes conscious of the repetitious nature of the material revealed in the interplay that goes on between the mother and her sick daughter. One does not feel that there has been any original contribution to the understanding of the schizophrenic girl and her difficulty arising out of morbid relationship with her mother. A somewhat better understanding of the dynamic aspects of the behavior of the mothers of these patients is demonstrated, but does not seem to be original.

The book is highly recommended to those interested in group therapy of schizophrenics. There are many aspects of it that would particularly appeal to the psychiatric social worker and the nurse, as well as the psychiatrist engaged in group work.

Dr. Abrahams and his co-worker, Miss Varon, have undertaken a rather difficult, but yet seemingly rewarding endeavor in the field of group therapy. Their vivid and revealing report of these sessions is evidence of their intense interest and emotional involvement in the group process.

JAMES J. LAWTON

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Brooklyn, New York

INTERRELATIONS BETWEEN THE SOCIAL ENVIRONMENT AND PSYCHIATRIC DISORDERS. (Papers presented at the 1952 Annual Conference of the Milbank Memorial Fund.) New York: Milbank Memorial Fund, 1953. 263 p.

This is the report of a symposium whose members included social scientists from the fields of public health, psychiatry, sociology, anthropology, psychology, and social psychology, convened to exchange information and ideas about research in social psychiatry. The volume contains formal presentations of their material and a report of the accompanying discussion.

Only a few papers can be discussed in this brief review; these were selected as examples of the broad range of the topics considered and the contributions that the various disciplines can make to this research field. The choice in no way reflects on the competence or value of the other papers.

Dr. Leonard A. Sheele, Surgeon General, U. S. Department of Health, Education, and Welfare, who gave the opening statement,

discussed some of the psychiatric problems in the public-health field whose solution would be more easily reached if we had more knowledge about the "interrelationship of social environment, human behavior, and human health—both individual and group." Our aging population presents new public-health problems, such as the prevalence of chronic disease, and the need to provide special community-health services and institutional care. Another problem is that of caring for older people in mental hospitals and preventing their need for institutionalization. Other public-health problems that call for social research relate to constructive community organization to meet needs and the development of effective communication of medical information to laymen.

Some of the major hypotheses concerning mental illness were presented by Dr. Eugene V. Schneider, assistant professor in the Department of Sociology and Anthropology, Bryn Mawr College. These are the inability of the individual to meet a "demand rôle," membership in groups that meets prejudice and discrimination, abrupt transition from one rôle to another, social disorganization that has emotional impact for the individual, inability to secure social acceptance, social mobility, incompatibility of values, isolation of the individual from social groups. He held that the hypothesis that the "disorientation of personality and society are the prime factors in mental disease" needs further study.

Dr. Benjamin Paul, lecturer in social anthropology, Harvard University School of Public Health, presented a paper on "Mental Disorder and Self-regulating Processes in Culture," giving as an example a Guatemalan girl whose case raises two major questions: "do the dynamics of mental disorder remain constant from culture to culture," and do the roots of psychopathology lie in the social process or do they originate in hereditary predisposition?

The second part of the volume deals with the "Definition of a Case for Purposes of Research in Social Psychiatry"; in other words, what should be studied and how should the findings be evaluated? It was pointed out that this is like asking, "What is mental health and mental illness? What is normal and what is abnormal?" The discussion brought out some of the criteria that are being used in various research studies. Several speakers pointed out that these relate both to an individual's interpersonal relations and to those aspects that relate to him as an individual with certain potentialities for development. Discussion around these points was lively, with give-and-take of ideas and questions and with the group moving toward clearer understanding of one another's points of view and definitions. The reader will get a real feeling of the group process and the value of

the conference method in communication and learning from the report of the discussion.

Several current research projects are reported, including, among others, the Stirling County Study, by Dr. Alexander Leighton; the Wellesley Project, by Dr. Erich Lindemann; the Yorkville Community Mental Health Research Study, by Dr. Thomas A. C. Rennie; and a project to evaluate a community mental-health project in St. Louis. This section provides a useful reference for those who wish to learn about some major research studies in mental health and social psychiatry.

The value of this conference report lies not only in the content, but also in its presentation of the social-science team in action, with the interaction between members of the symposium, the blocks in communication, and the movement toward understanding of one another's special contributions. We are once again indebted to the Milbank Memorial Fund for providing us with stimulating material to read and discuss.

HELEN SPEYER

The National Association for Mental Health

MORE CLINICAL SONNETS. By Merrill Moore. New York: Twayne Publishers, 1953. 72 p.

Here are further realistic, psychiatric, humane portraits, in unconventional, but intelligible verse, of men and women as they live or try to live. Representative titles are *A single raven in a lonely wood, Her love was as complicated as algebra, He said his wife was most remarkable . . . , Lawyer, Women's eyes in tea-rooms,* and *Poets have nothing to hide.* Edward Gorey's drawings reinforce the themes.

The whole seems to justify two of the conclusions:

> "Man is not entirely a bestiary
> Even though noisier than necessary."
>
> "The poets with insight
> Are antidotes for certain kinds of fright."

W. S. TAYLOR

Smith College, Northampton, Massachusetts

NOTES AND COMMENTS

Fifth International Congress On Mental Health

The Fifth International Congress on Mental Health was held at Toronto, Canada, August 14-21, 1954. It was attended by over 2,000 people from approximately 50 countries, coming from such far-away places as Turkey, the Sudan in South Africa, Ceylon, Australia, and New Zealand. One was impressed with the variety of English accents overheard in the different racial and cultural groups represented among both participants and audience.

The general theme of the congress was Mental Health in Public Affairs, developed in five sub-topics: Areas of Partnership in Public and Mental Health, the Mental Health of Children and Youth, Mental Health in Governmental Activities, Community Partnership in Mental Health, and Professional Advances in Mental Health.

The five plenary sessions were inspirational in character with outstanding people from many countries presenting papers. The opening session brought messages from representatives of the six continental regions: the Sudan, Ceylon, Australia, Switzerland, the United States, and Venezuela. The speeches by Sir Geoffrey Vickers, of London, on Mental Health and Spiritual Values, by Dr. Ronald Hargreaves, of the World Health Organization, by Dr. G. Brock Chisholm, formerly Director-General of the World Health Organization, and by Mrs. Eleanor Roosevelt, were especially meaningful to a mental-health audience.

The technical sessions provided the scientific content of the congress, and it was in these that reports of mental-health activities, treatment methods, and research in various parts of the world were considered. Several informal working groups developed out of the technical sessions, which brought together workers from many countries who wanted to discuss specific or practical aspects of their work.

Three research symposia met for several days before the congress with invited participants from the social-science field in many countries, including Canada and the United States. These considered the topics, Industrial Mental Health, Child Development, Alcoholism and Drug Addiction. Reports of their deliberations were given at the appropriate technical sessions.

In addition to the main program were round tables, organized primarily to meet the needs of lay workers. These considered Mental

Health and Education, Parent Education, and the Rôle of the Volunteer in Mental Health.

The congress was preceded by the First International Congress on Psychotherapy and the International Institute of Child Psychiatry. The majority of people who attended these remained for the congress and many contributed their specialized knowledge to the research symposia and the technical sessions.

International congresses represent an immense amount of time, work, and money. Their value may be measured in general as well as in specific terms. This mental-health congress, like the former ones, contributed to better communication and understanding between professional and lay workers in many countries and emphasized the interdisciplinary nature of mental-health work. It provided a forum for the exchange of ideas and of technical developments. It also brought together people from countries who could not meet and discuss on a face-to-face basis unless there were such congresses, because of the difficulties of distance, language differences, and travel costs. These personal contacts are important, not only for good human relations, but because ideas exchanged and plans discussed in informal talks often result in the practical implementation of our broad plans and hopes.

For the results of the congress to be really effective, the stimulus provided must be used by mental-health associations in this and other countries to improve interdisciplinary work, to exchange information about research, treatment methods, and the training of personnel, and to develop meaningful activities at the community level, where people live and work. Rich material has been provided for public education and interpretation, but its effective use and application are the responsibility of the mental-health associations in the United States and other countries, and of the individual citizen, whether he be a professional or lay worker.

HELEN SPEYER

FAREWELL STATEMENT OF DR. ALBERTO SEGUIN, OF LIMA, PERU, ON HIS RETIREMENT FROM THE BOARD OF THE WORLD FEDERATION FOR MENTAL HEALTH

In finishing my service as a member of the Executive Board of the World Federation for Mental Health, I wish to say a few words to you—not as a farewell, because I shall consider myself always as a part of the federation and I shall do my best to be useful to it—but as a token of gratitude and a testimony of admiration.

It has been wonderful indeed to be with you, to work with you, to share experiences, worries, and satisfactions, and to see how decision,

good will, and the conviction of performing a useful and necessary task can accomplish so much with so little. I have learnt how not to be discouraged when in difficulties and how to find in enthusiasm a substitute for power, and I have learnt how not to be conceited when triumphant, replacing vanity by sober criticism and constructive encouragement; I have shared faith in the future of a work well done and belief in the possibilities of mankind; I have admired seriousness of purpose and resoursefulness, unfailing will and gentle manner, and I have been taught how to be humble, yet unyielding, good-humored, yet firm.

For all this I am grateful to you, but I want my gratitude to be only a part of the gratitude of a whole continent. I want Latin-America to receive the benefits of your work and your capacity and to be thankful as I am. Our countries are in great need. They are new, full of possibilities, and ready to be good partners and useful contributors, but they need first to be awakened and guided. I, on their behalf, want my last words to be those of a call and hope, of an appeal and expectation.

Memorial To Sigmund Freud

On the anniversary of the birth of Sigmund Freud—May 6, 1954—in the presence of about 200 guests, who included the two deputy mayors of the City of Vienna, the rector of the university, and the dean of the faculty of medicine, a memorial plaque was unveiled on the outer wall of 19 Berggasse, Vienna.

During the Sixth Annual Meeting of the World Federation for Mental Health, in Vienna, in August, 1953, a number of people who made a pilgrimage to see this house discovered that it was not marked in any way, and spontaneously made the suggestion that the whole group should subscribe toward the cost of a commemorative tablet. The Austrian Society for Mental Hygiene contributed the balance of the funds and made all the arrangements for the erection of the plaque. The inscription on it reads:

> *" In diesem Haus lebte und wirkte Sigmund Freud, in den Jahren 1891–1938, der Schöpfer und Begrunder der Psychoanalyse. Gestiftet von der 6. Jahresversammlung der World Federation for Mental Health im August, Wien, 1953."*

Professor H. C. Rumke, of Utrecht, President of the World Federation for Mental Health, attended the ceremony and gave the first address, followed by Professor Hans Hoff, professor of psychiatry in Vienna and Chairman of the Austrian Society for Mental Hygiene. The wording on the plaque had been submitted beforehand to Miss Anna Freud, who had given her full approval to it.

On the evening before the unveiling, Dr. Winterstein, President of the Austrian Psychoanalytical Association, at a special meeting, read a paper on the relation between Freud and Goethe.

Institut de Psychanalyse Opened in Paris

The Institut de Psychanalyse, Paris, was formally opened on the 1st of June, under the presidency of Monsieur André Marie, Minister of National Education, and of Monsieur Paul Coste-Floret, Minister of Public Health and Population.

Located in the Latin Quarter, the heart of the liberal and university traditions of Paris, the institut consists of a training center in the theory and practice of psychoanalysis—the only such center in France accredited by the International Psycho-Analytical Association—and includes a psychoanalytical-therapy clinic.

Monsieur Emile Roche, President of the Conseil Economique, manifested his interest in this important development by sending a representative.

Among the great number of officials present were Professeur Piedelievre, President of the National Council of L'ordre des Medecins (Medical association), the representative of Monsieur Sarrailh, Rector of the University of Paris, many professors from the school of medecine and the arts schools, doctors from Paris hospitals and psychiatric hospitals as well as eminent personalities of the Bench and Civil Service.

Dr. Male, President of the Societe Psychanalytique de Paris, Dr. Nacht, Director of the Institut de Psychanalyse, Dr. Cenac, head doctor of the clinic, Mme. Marie Bonaparte, Vice-President of the International Association, Dr. Jones, Honorary President of the International Psycho-Analytical Association, each in turn underlined the importance of this institution.

In his address, the minister of national education emphasized the extent to which the new institut is being integrated into the general development of the organization of higher education.

Care of the Mentally Ill in Alaska

House Resolution No. 8009, Section 33, for the 83rd Congressional Session, includes a statement of policy for Alaska which makes clear the intent with respect to the mentally ill. The Governors' Conference in Detroit urged that all states clearly define policy. The Alaska statement reads as follows:

> "Every patient shall be entitled to humane care and treatment and, to the extent that facilities, equipment, and personnel are available,

to medical care and treatment in accordance with the highest standards accepted in medical practice.''

Institute on Better Social Services for Mentally Ill Patients

An Institute on Better Social Services for Mentally Ill Patients was held at Lake Forest Academy, Illinois, June 12-18, under the auspices of the American Association of Psychiatric Social Workers, assisted by a grant from the National Institute of Mental Health. Thirty-eight states, Puerto Rico, and Canada sent representatives. Approximately 100 social workers participated, most of whom carry major responsibility in social-service programs in psychiatric hospitals. Chief social workers in state departments of mental health were delegated by the governors to attend where such a state position exists. In other states, a chief social worker from a psychiatric hospital was designated by the governor or director of the department of mental health to attend. Psychiatric social workers from the Veterans Administration, the armed forces, private psychiatric hospitals, and neuropsychiatric departments of general hospitals were also invited. Resource people from allied professions and interests included consultants from psychiatry, psychology, psychiatric nursing, group work, vocational rehabilitation, family service, and public welfare.

The institute was designed to provide opportunity through small workshops for an exchange of ideas among responsible representatives in social-work programs in hospitals for the mentally ill in state, federal, and voluntary programs.

The topics discussed in the five workshops that ran concurrently through the six days were: essential social services and priorities in program development; staff qualifications; in-service training; administration; and community-mental-hygiene education. Special programs, such as group work, foster-family care, after-care clinics, day and night hospital care, and children's services were discussed in terms of skills required, personnel needs, and program development. In addition to the workshops, the program included speakers known for their outstanding accomplishments in the treatment of the mentally ill.

Emphasis was placed on consideration of the hospital as a therapeutic community, with all personnel coöperating closely in a continuous effort toward the patient's rehabilitation. While shortage of personnel often prevents social-service departments from providing optimum service, the group considered it highly desirable that contact both with patients and with families begin at admission and

continue throughout, so that planning for the patient's return to community life would be a continuing process. The point was stressed that the actual hospitalization is only a stage in the patient's illness and that help in the social adjustment of the patient is needed before, during, and after hospitalization. In view of the severe shortage of social workers in mental hospitals, serious attention was given to the best possible use of existing personnel, to the delineation of services that might be carried by aides or technicians, and to programs enabling untrained personnel in social-service departments to undertake graduate training.

Closer integration of hospital and community was urged. It was felt that social workers had a major responsibility in efforts to bridge the gap between hospital and community. With the increasing number of patients returned to the community because of advances in psychiatric treatment, the greater demands of after-care programs necessitate imaginative and efficient coöperation between hospital social services and community health and welfare resources.

Social workers in hospitals felt that one of their responsibilities is to engage in community-mental-hygiene education. They stressed the value and importance of working through existing agencies engaged in this work, such as The National Association for Mental Health.

Stress was placed on the need for research and for demonstration projects to assess the effectiveness of present methods and programs for the social rehabilitation of the mentally ill patient.

It is anticipated that the full proceedings of the institute will be published in the early fall.

The Ellis Case

The following release on the Howard Ellis case was recently sent out by the Information Service of the Indiana Association for Mental Health:

> "Recently the Central State Hospital at Indianapolis rehabilitated a woman who had been the hospital with a mental handicap for thirty years.
>
> "Once friendless, penniless, and sick-in-mind, she now has a job, a home, money in the bank, and the respect of her neighbors and friends.
>
> "This year about 3,000 patients will be discharged from the 10 Indiana state hospitals. Most will join the ranks of the 50,000 Indiana citizens who once, too, had been patients in state hospitals and other psychiatric facilities.
>
> "On the whole, the 50,000 living Hoosiers who had once been mental hospital patients have become wage-earners, home-makers, producers, and good peace-loving citizens.
>
> "The case of a woman who was rehabilitated after 30 years does

not make the headlines. The successful lives of 50,000 living former mental hospital patients do not make the headlines, either.

"One patient did make the headlines.

"Nobody probably will ever know what happened to Howard Ellis and what prompted him to resist in the manner he did the efforts of his wife to have the police apprehend him and return him to the Central State Hospital. He had been out for 18 months. Up until a week before the now famous incident in which he was involved, his wife reported him in good condition and asked that his six months' leave be extended for the third time.

"He had been known as a docile man, gentle and kind to children.

"But on June 30, 1954, he made eight-column headlines. His wife reported that he required hospitalization again. She was instructed to call the police to return him.

"The police came to apprehend him and for two hours, this formerly meek person, who in his ignorance could neither read nor write, fought them off in a running gun-battle.

"He stood off 100 officers and two armored trucks. In the course of this his house was riddled, his wife wounded, and eight policemen were sent to Iindianapolis's General Hospital.

"When it was over, he was dead. Twenty-three bullets were in him.

"The public is naturally shocked.

"The Indiana Association for Mental Health believes that for former mental patients and their families, however, the tragedy is great, too.

"Former mental patients and their families fear a recurrence of the superstitions and false beliefs that once brutally characterized all mentally afflicted people as 'dangerous.'

"Mental patients are just coming out of an era in which they have been regarded with many false notions. Only recently has society seen them as sick persons, responsive to treatment and kindness.

"Their tragedy will be great if this one isolated example is used as the basis for a generalization about all former mental patients.

"Snap judgments, if such exist, may impede the efforts of state hospitals to do their job, which is to treat and restore sick people to their families and to their communities.

"Such judgments would also impede the efforts of former mental patients to reëstablish themselves in the community.

"The truth is that the public is safer from the 50,000 former hospitalized mental patients than it is from any other group in society.

"State hospitals have conservative records in screening every person they discharge for social risks.

"This is borne out by the records of former patients and police bureaus alike.

"In Indianapolis, for example, there have been 297 homicides since 1945.

"No veteran homicide officer recalls any former hospitalized mental patient as being involved in any of 297 homicides, (although such a case may possible have taken place beyond recall).

"'This case is exceptional,' said Homicide's Captain Robert Reilly.

"In his experience, the mentally ill are more like frightened sheep than the mad dog one might suspect from the furor caused by this isolated case.

"Former hospitalized mental patients are rarely involved in homicides or dangerous actions such as Howard Ellis's.

"The big fear of law-enforcement officers is not homicide, but suicide. This is particularly true in persons not yet hospitalized, who have been picked up for treatment, but kept in jail due to the dearth of treatment facilities and the red tape of time-consuming commitment processes.

"Suicide attempts have been frequent and sometimes have been successful. On June 1st, most recently, a sick man was picked up by the police for mental examination and detained in the city lock-up. He successfully hung himself in an isolation cell. Turnkeys report that on a number of occasions they have foiled attempts only with seconds to spare.

"Homicide's Captain Reilly states, 'There will be absolutely no change in our routine of treating every suspected case as a sick person. We know they are sick and do not hold them responsible for their action.

" 'When we go down the street and see a person who is physically handicapped, we give him our sympathy and understanding.

" 'We recognize the mentally ill person is a sick person and believe that he should have the same kind of sympathy and understanding.'

"The Indiana Association for Mental Health believes that the Howard Ellis case obviously cannot be the basis for generalizations about all people who have once been in mental hospitals.

"It believes that in the long run the daily lives of an ever-growing number of former hospitalized mental patients will speak more clearly for them than the dramatic impact of this exceptional case."

Rehabilitation Of The Mentally Ill

The following data on the rehabilitation of the mentally ill are quoted from a fact sheet provided by the Office of Vocational Rehabilitation and distributed by the National Institute of Mental Health:

"As the concepts of care and treatment of the mentally ill have widened in recent years, it has become apparent that a substantial proportion of the mentally ill can be rehabilitated successfully and restored to productive work and responsible places in their communities. Vocational-rehabilitation agencies, working both with treatment clinics and with hospitals for the mentally ill, have made steady advances both in the numbers of persons served and in the improvement of techniques in planning and carrying out individual rehabilitation programs for these persons.

"During 1953, seven more state vocational rehabilitation agencies set up special programs and assigned special counselors to serve the mentally ill. This brought to 22 the number of agencies with such specialized programs, working in well-defined coöperative plans with state mental hospitals.

"During the last ten years, the number of persons in the mentally ill group who have been rehabilitated has risen slowly, but consistently.

In 1944, the first year in which services to this group by the public rehabilitation program were authorized by law, slightly less than 1,000 were restored to suitable employment. In the succeeding years, the number mounted regularly until, in 1951, more than 2,600 were rehabilitated and the figure is still climbing. Among the 1951 group, the diagnoses indicated 61 per cent with psychoneuroses, 23 per cent with psychoses of various types, 5 per cent designated as psychopathic personalities, and the balance suffering other types of emotional disorders.

"The individuals, following rehabilitation, entered a variety of types of work, with the distribution comparing favorably with the spread of employment fields among workers generally. This is indicated by the following percentages according to major types of employment:

23%—clerical and kindred	9%—professional, semi-professional and managerial
15%—service	7%—homemakers and family workers
14%—semi-skilled	6%—sales and kindred
12%—skilled	5%—agricultural and kindred
9%—unskilled	

"With more than 600,000 hospital beds in this country designated for the care of the mentally ill, the number of patients rehabilitated annually through the public program obviously represents only a small fraction of the total. Some of those now institutionalized cannot be expected, even with the best professional knowledge and service available today, to respond sufficiently to resume normal lives in their communities. Yet, as Mary E. Switzer, Director of the Office of Vocational Rehabilitation, points out:

"'We may look to future success by our research scientists for new knowledge in treating those mentally ill persons who do not respond to any present treatment methods. But we must look to ourselves and to the resources of our society to-day for a better way of extending the knowledge we already have, the known and successful procedures of treatment and rehabilitation, to those who *would* respond. The opportunities are enormous.'"

U. S. Grants for Medical Research Projects

The Surgeon General of the Public Health Service, U. S. Department of Health, Education, and Welfare, has announced approval of federal grants for 1,442 medical-research projects, totaling $14,685,671, for basic and applied research in the major diseases afflicting Americans to-day. The grants were approved during recent meetings of the seven national advisory councils.

Four hundred and fifty-nine of the awards, totaling $4,568,073, were for new research projects; 983, totaling $10,117,598, were for continuation of existing projects.

The awards were made to scientists in 335 research institutions in the United States and are administered by the National Institutes of Health, research bureau of the Public Health Service.

A tabulation of the grants follows:

	No. of grants		Amount
National Institute of Arthritis and Metabolic Diseases	66	(New)	$ 629,271
	146	(Cont.)	1,375,263
National Institute of Neurological Diseases and Blindness	55	(New)	471,178
	140	(Cont.)	1,327,089
National Cancer Institute	92	(New)	981,074
	195	(Cont.)	2,182,395
National Institute of Dental Research	10	(New)	73,292
	13	(Cont.)	113,873
National Microbiological Institute	77	(New)	610,620
	64	(Cont.)	704,863
National Heart Institute	81	((New)	912,938
	213	(Cont.)	2,283,370
National Institute of Mental Health	25	(New)	373,178
	42	(Cont.)	569,393
Division of Research Grants	53	(New)	516,522
(For categories of medical and public-health research not within the scope of the 7 institutes)	170	(Cont.)	1,561,352
Totals	1,442		$14,685,671

College Courses for Student Nurses Instituted by New York State Department of Mental Hygiene

All first-year students in the 18 state department of mental-hygiene schools of nursing will study both on a college campus and at a hospital this fall.

Commissioner Newton Bigelow, M.D., has announced that Brooklyn, Manhattan, and Rockland state hospitals schools of nursing will send their first-year students to New York University for courses in arts and sciences under an agreement that has just been completed. The 15 other schools of nursing in the department have arrangements with recognized colleges or universities in their areas.

Approximately 350 nursing students will be attending college classes in September, under the department's collegiate freshman plan, which began on a limited scale four years ago. The plan is in line with present-day trends in professional nursing education, Dr. Bigelow said. Credits that students earn may be applied toward a college degree at a later date.

Nursing students will take the same courses as regular college science students for four days a week, and will have the full use of college classrooms, laboratories, and libraries, and an opportunity to take part in college activities. On the fifth day, they will receive instruction in nursing arts at the home school.

At the end of the academic year, the students will continue training in the nursing arts at their home school on a full-time basis until

the beginning of the second year, when they affiliate in a general hospital to receive instruction and experience in clinical nursing. They return to their home school in the third year for advanced nursing instruction, which includes psychiatric nursing.

Philadelphia Firm Inaugurates Pre-Retirement Plan

A pre-retirement plan inaugurated by the John B. Stetson Company, of Philadelphia, is reported by Herbert W. Gruber in *Aging*, a periodical of the U. S. Department of Health, Education and Welfare:

> "Under the leadership of Horton B. Delaney, a plan was developed to assist employees in preparing themselves for the transition from work to retirement. The program consists of a series of group sessions covering the following subjects relating to retirement—(1) Attitude Clarification, (2) Economics or Finances, (3) Health, (4) Family Life and social relationships, (5) Leisure time activities, (6) review and employee reactions. The Health and Welfare Council [of Philadelphia] served in an advisory capacity and assisted in relating the community resources to the program. This company has no compulsory retirement age; therefore, many of the employees are in their seventies. Since January the plan has been presented to three groups of about 20 each. Attendance was by invitation and represented the older employees. However, the company plans, as soon as practicable, to reach employees within 5 to 10 years of retirement."

Mental-Health Committee Formed by New York City Welfare and Health Council

Formation by the Welfare and Health Council of New York City of a mental-health committee, representing private and public agencies on a city-wide basis, was made public recently by J. Donald Kingsley, executive director of the council.

Chairman of the new group is Mrs. Eric Haight, President of The Spence-Chapin Adoption Service and a board member of the council and of the Citizens' Committee on Children of New York City.

The committee has two major charges: (1) to study mental-health programs and activities here, paying special attention to preventive aspects, and to make recommendations of a broad policy nature to appropriate agencies to help strengthen and expand services; and (2) to gather information on mental-health resources and facilities in order to help agencies take fullest advantage of the Community Mental Health Services Act, passed at the last session of the legislature. This law permits state reimbursement to certain local mental-health programs, and offers a potential $8,000,000 annual reimbursement within New York City.

The committee, which will work during the summer to establish priorities, will coöperate with local organizations doing related work.

"The need for a coördinating and planning body in the field of mental health has long been recognized by health and welfare leaders," Mr. Kingsley declared. "The passage of the Community Mental Health Services Act serves to heighten that need. In addition, agencies realize that they must not only develop their programs, but must try to integrate their services with others in the community. There is also an urgent need for closer continuous working relationships between various professional groups, as well as between professional groups and laymen. These are some of the areas the new committee will work in."

The council is a voluntarily supported coördinating and planning organization for more than 370 public and private welfare and health agencies here. Carl M. Loeb, Jr., is president.

Multiple-Sclerosis-Heredity Study Gets Under Way

Approximately 35 pairs of twins, from nineteen states throughout the United States and Canada, responded to the recent nation-wide appeal for identical twins afflicted with multiple sclerosis, according to Dr. Harold R. Wainerdi, Medical Director of The National Multiple Sclerosis Society.

As a result of the successful appeal, made with the coöperation of hundreds of newspaper editors, preliminary verification for research into the possible hereditary and environmental causes of the crippling disease has got under way. Through its committee on genetics, the society plans to begin its research project as soon as sufficient data on the volunteer twins have been amassed, and examples of twins have been selected to meet the rigid requirements of the proposed study.

One of the prime tasks now will be to sift and corroborate data on the twins, to make sure (1) that they are identical and (2) that one has multiple sclerosis or that both have. For purposes of the planned research, the "ideal" twins would be those sets one member of which has multiple sclerosis and the other has not. Both would be studied to try to determine factors that may have been responsible for the disease in the afflicted twin.

In order to differentiate actual identical twins from non-identical twins of the same sex, careful studies of un-retouched photographs, fingerprints, blood groupings, and hair patterns will be made.

Multiple sclerosis is a disease of the central nervous system. It attacks the protective nerve covering (myelin) in areas on the brain and spinal cord, thus causing scar tissue to form and block nerve

pathways. The result is an impairment of vital body functions, bringing symptoms such as: lack of balance and coördination; numbness of parts of the body; tremors; defective vision; slurred speech; and bladder difficulties. Multiple sclerosis is often referred to as "the disease of young adults," since it most frequently strikes persons within the twenty-to-forty age bracket. Its victims are incapacitated in varying degrees; some are able to walk with or without aid of cane or crutches; still others are confined to wheelchairs or are bedridden. The cause and cure of the disease are as yet unknown.

The society's appeal for identical twins is continuing and volunteers are asked to contact The National Multiple Sclerosis Society, 270 Park Avenue, New York 17, N. Y.

Dr. Joseph J. Reidy Heads Astor Home

The Astor Home, a residential treatment center for emotionally sick boys at Rhinebeck, New York, announces the appointment of Dr. Joseph J. Reidy as medical director. Dr. Reidy assumed his responsibilities July 1, 1954, succeeding Dr. Emil G. Piana, who had been medical director since the center opened in January 1953.

The Astor Home functions as one of the three pilot projects under the auspices of the New York State Mental Health Commission. Initiated by the New York Catholic Charities to help bridge the gap in its existing program of services for children, it now accommodates 27 patients. A new wing to provide ten professional offices, four classrooms, and a recreation unit comprising four playrooms and gym, will release some space in the existing building for additional children. Completion of the new wing is expected early in 1955.

De Paul Sanitarium Becomes De Paul Hospital

De Paul Sanitarium, of New Orleans, Louisiana, has announced that it will henceforth be known as De Paul Hospital.

De Paul Sanitarium was organized in 1861 by the Daughters of Charity of St. Vincent de Paul and has given continuous service to the public in the South. It is now an open staff hospital, with recognized supervisors and an affiliated training school, which up to the present has trained approximately 2,000 students in psychiatric nursing. The hospital is accredited for residency in neuropsychiatry. The present administrator is Sister Henrietta Neuhoff. Dr. William J. Otis is neuropsychiatrist in chief.

Design for Happy Mealtimes

The Merrill-Palmer School of Detroit, Michigan, has produced a new filmstrip, *Design for Happy Mealtimes,* based on new findings and

points of view, as well as on many years of experience in working with children and families at the school.

A discussion guide accompanies the filmstrip, giving the basic outline and underlying philosophy followed.

The first part of the filmstrip shows practices followed in feeding young children in the Merrill-Palmer Nursery School. The second part shows the application of these practices to the home and family situation.

It is believed that the new filmstrip will be found helpful to many teachers and other professional persons responsible for guiding students, dietitians in training, and parents in the important task of making mealtime a happy time, whether in the home or in school and other groups outside the home.

The new filmstrip may be ordered from the Library of the Merrill-Palmer School, 71 Ferry Avenue, East Detroit 2, Michigan, at $3.50 a print.

New Monthly Started by Ohio's Department of Mental Hygiene and Correction

The first issue of a periodical that will be issued monthly by Ohio's new Department of Mental Hygiene and Correction made its appearance in August. According to the statement of its editor, Dr. John D. Porterfield, *Motive*, as the new magazine is entitled, will have the task "of portraying to the people of Ohio the meaning and background of the department's responsibility — the care, the cure, and the prevention of juvenile and adult misbehavior, of mental disease and deficiency.

> "It is not difficult to find a common theme in the department's programs. Motive is defined as that which causes one to act in a certain manner. None of us knows very much of the long-branching and often obscure causes which reach back in the life of an individual and result in his world becoming too big a problem for him, and he a problem for his world. The effects we know. We have attempted to protect the world by isolation. We have built institutions and added to them. We must build more institutions and add to them as long as we do not solve the problems, but only contain them.
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> "Hope grows every year that we may find ways to solve the problems. New medicines, new treatment, new methods of training and retraining go father than simple isolation. Each year a greater percentage of persons return to their free world from isolation, happy, secure, and productive. The percentage is still too low and must be increased. We must learn more and we must do more to provide satisfactory adjustment between the miscreant, the deficient, the ill, and the world they live in. It will be their saving. It will also be the world's.
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> "More than isolation is cure. More than cure is prevention. When we find motive, when we understand motive, even though it be not

always logical, perhaps then we can begin to prevent. No one can underestimate the difficulties of prevention. It is neither simple nor immediately at hand. But only by searching for the means of prevention can we have real hope for the future.

"So the new department has three basic responsibilities: to isolate adequately for the protection of the world, to treat vigorously and to cure when possible for the sake of the individual, to find and to apply the means of prevention for the assurance of our future."

Announcements of Meetings

The fourth Annual Meeting of The National Association for Mental Health will be held at the Hotel Statler, New York City, October 23, 24, and 25, 1954. Dr. Alan Gregg is to be the speaker at the banquet; Dr. Robert H. Felix will speak at the closing session; and Mr. Albert Deutsch will give the keynote address at the start of the meeting.

Considerable emphasis will be placed on giving those who attend an opportunity for free discussion of their various programs. Two of the sessions have been designated as "idea exchanges" at which it is planned to discuss new and interesting techniques.

There will also be the customary research luncheon, at which reports will be presented on the latest research on mental problems.

The first Northwest Institute on Serving the Needs of our Aging Population will be held at the University of Washington, Seattle, November 11, 12, and 13, 1954. Two nationally known speakers who will address the institute and be available as consultants are: Dr. Wilma Donahue, Director, Division of Gerontology, University of Michigan, Ann Arbor, Michigan; and Mr. Clark Tibbitts, Chairman, Committee on Aging and Geriatrics, U. S. Department of Health, Education and Welfare, Washington, D. C.

Other experts, in the fields of physical and mental health, employment and economic support, housing and living arrangements, education, recreation and leisure-time activities, rehabilitation and home services, will lecture, participate as panel members, and lead informal discussions.

The American Group Psychotherapy Association will hold its Twelfth Annual Conference at the Henry Hudson Hotel in New York City, on Friday and Saturday, January 14 and 15, 1955.

The Friday afternoon session will be devoted to a series of workshops dealing with The Utilization of Group Psychotherapy in Child Guidance, Problems of Group Psychotherapy in Private Practice, Resistance in Group Psychotherapy, Methods of Initiating the First Group Session, and The Use of Multiple Therapists in Group Psychotherapy.

Scientific papers will be presented Friday evening by S. R. Slavson, Dr. Fitz Redl, and Dr. Geraldine Pederson-Krag. On Saturday morning, January 15, a series of panels will be held dealing with Group Psychotherapy in the Treatment of Psychosomatic Disorders, The Use of Art in Group Psychotherapy, Types of Group Psychotherapy Used in the Treatment of Psychotics, Group Psychotherapy in the Treatment of Addictions, Group Psychotherapy in the Treatment of Special Problems, and a Case Presentation by a Psychotherapeutic Team.

The conference will close with two sessions on Saturday afternoon at which papers will be presented on Special Aspects of Group Psychotherapy, with workshops and panels by the reporters and chairmen.

Among the participants are: Dr. George S. Stevenson, Dr. Samuel B. Hadden, Dr. Hyman Spotnitz, Dr. George R. Bach, Hendrik Lindt, Dr. James A. Shea, Dr. Saul Scheidlinger, and Ruth Fox.

The Child Study Association of America will hold its Annual Conference on Monday, March 28, 1955, at the Hotel Astor in New York City. The topic will be: "Living and Growing with our Children: The Emotional Impact on Parents of Typical Growth Phases of Childhood."

On Tuesday and Wednesday, March 29 and 30, there will follow at the same hotel the Institute for Workers in Parent Education.

Recent Publications

The philosophy behind a new, effective approach to public education is described in a small booklet recently published by the New York State Department of Mental Hygiene.

In releasing the booklet, Commissioner Newton Bigelow, M.D., indicated that its purpose is to explain "why this department uses comic books, puppet shows, and similar media to teach the principles of good mental health." The report summarizes five years of activity in a new educational program which attempts to reach the man on the street by speaking his language and using ideas that he can grasp and accept.

Discussing the problem of mass education, the booklet points out that "there is no homogeneity of background, no community of interest, and no established motivation. We must reach out to an assorted body of indifferent human beings, command their attention, enlist their interest, beat down their resistance, and communicate with them in terms that they will understand."

The title of the booklet, *The Ear of the Beholder,* is taken from a quotation that appears on the title page; "While beauty may be said to

lie in the eye of the beholder, it is a scientific truth that sound does not exist save in the ear of the beholder. In much the same way, no words of wisdom, however cogently expressed and vehemently spoken, can ever find their mark unless they are heard and understood."

Educational aids produced by the department of mental hygiene in accordance with this philosophy have been widely acclaimed in the mental-health field and most of the popular publications have been adapted for use in other states.

One of the most successful of the unorthodox devices used in the program is the Haunted House exhibit, first shown at the state fair last fall. Humorously exploiting the theme, "Are You Living in a Haunted House?" the project deals with fear — the basis of most emotional difficulties — pointing out that many of the fears that haunt us are foolish, unfounded, or unnecessary. "The 35-foot exhibit was so constructed," the booklet explains, "that visitors could actually enter a creaking door and prowl through dark passages inhabited by disappearing ghosts, skeletons, bats, spiders, and assorted phantoms. This spine-tingling safari was punctuated by whispering voices which asked the visitors some soul-searching questions. While the thrills and horrors of the haunted house were presented with tongue in cheek, the messages dealt with serious problems: Are you haunted by ghosts of the past? Is there a skeleton in your closet? Are you afraid of to-morrow?"

The public responded to this unusual educational effort by storming the creaking door. All during the fair, long lines of visitors waited patiently for a chance to enter, and many had to be turned away each evening when it was time to close. "We had no choice," Dr. Bigelow said, "but to schedule a repeat appearance of the Haunted House at this year's state fair in September."

The booklet, which is available to agencies and organizations engaged in mental-health education, was written by Margaret M. Farrar, director of the program.

An attractive little pamphlet with the title, *The Nurse's Rôle in the Mental Health Program*, has been issued by the National Institute of Mental Health, of the U. S. Department of Health, Education, and Welfare. The pamphlet, which was prepared by three nurses — Mary Corcoran, Esther Gabrison, and Pearl Shalit — points out clearly and simply the opportunities offered to the nurse to foster mental hygiene in her everyday contacts not only with her patients, but with every one with whom she comes in touch in her professional life. "Every professional contact she makes," the pamphlet states, "offers a challenge which, if she meets it constructively, will enable the nurse to build toward sound mental health in all our people."

Some of the basic principles of mental health are then given and suggestions are made as to how the nurse can help to promote them. The pamphlet closes with a short list of source materials — books, films, and transcriptions of radio programs — with information as to where each can be obtained. Copies of the pamphlet are for sale by the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C. Price 15 cents.

The Division of Mental Hygiene and Hospitals, New Jersey State Department of Institutions and Agencies, Trenton 7, New Jersey, has issued a new directory of community psychiatric clinics in New Jersey. This supersedes the "Directory of Mental Hygiene Clinics in New Jersey" issued in 1950. The department expects to issue the list biennially. Copies may be secured without charge by writing to the Department of Institutions and Agencies.

The National Institute of Mental Health, of the U. S. Department of Health, Education, and Welfare, has brought out a 5-page leaflet on the rôle of the police in mental health. This leaflet was prepared by Rhoda J. Milliken, former Director of the Women's Bureau of the Metropolitan Police Department, Washington, D. C. Its purpose is "to suggest that the police officer's contacts with a child or adolescent in trouble and with the family can be a constructive force in helping the young person to develop more acceptable patterns of behavior." For more detailed information, a list of useful pamphlets and films is given at the end of the leaflet.

Copies can be purchased from the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C., at 5 cents each, with a discount of 25 per cent on orders of 100 or more to be sent to one address.

A recent publication in the field of cerebral palsy is a booklet by Morris Klapper, Executive Director of United Cerebral Palsy, New York City. *Basic Concepts in Community Planning for the Cerebral Palsied*, as the booklet is titled, is divided into three sections, dealing, respectively, with (1) "Essential Direct Services," including outpatient diagnostic and treatment centers, inpatient or residental treatment centers, permanent resident facilities, educational facilities, recreational and group-work facilities, and vocational-guidance training, and placement; (2) "Essential Indirect Services," research, public relations, stimulation of legislative action, and fund raising; and (3) "Concepts for Effecting Administration," which discusses the rôle of the voluntary health agency and the growth and structure of united cerebral-palsy associations. The booklet closes with a bibliography of publications in the field. Copies may be obtained at a price of

20 cents each from United Cerebral Palsy of New York State, 1475 Broadway, New York City.

Highlights of the 1954 National Health Forum, a digest of a significant national discussion of the health personnel problem, is now available from the National Health Council, of New York City. The forum, a feature of the council's thirty-fourth annual meeting, brought together voluntary and governmental health leaders, educators, and vocational-guidance specialists for a two-day discussion of the "Changing Factors in Staffing America's Health Services."

Highlights includes the facts and suggestions brought out in five discussion groups, concisely presented and interspersed with boxed quotes of significant statements on health personnel. (The list of the eighty program participants is in itself an abbreviated "Who's Who in Health.") Digests of the major speeches of the Forum, by Dr. Detler W. Bronk and Dr. Franklin D. Murphy, are also included; and the final summary gives recommendations for action — one of which is already being put into effect in the council's new project, "Operation Health Career Horizons."

Highlights can be obtained from the National Health Council, 1790 Broadway, New York 19, New York, at a price of 75 cents a copy; special rates on orders in quantity.

Suggestions as to gifts for children in schools and colonies for the mentally deficient are listed in a little booklet put out by the Milwaukee County Society for Mental Health. The suggestions are classified under headings — "Personal Items," "Art, Craft and Stationery Supplies," "Games," "Group Gifts," etc. Copies, at 25 cents apiece, can be supplied by the Milwaukee County Society for Mental Hygiene, 111 E. Wisconsin Avenue, Milwaukee 2, Wisconsin.

The Secretary General of the Dutch National Federation for Mental Health, Mr. H. Nieuwenhuize, has called our attention to a booklet — *Mental Health in the Netherlands* — put out by the federation with the coöperation of the Ministry of Social Affairs and Public Health. Dr. A. Querido, president of the federation and Director of Public Health of the City of Amsterdam, is the author of the booklet.

Written in English and illustrated with colored graphs, the booklet deals briefly and clearly with the historical development of mental-hygiene work in the Netherlands, the organization of the work, the care and after-care of mental patients, the education and care of the feebleminded, the mental health of children, the treatment and prevention of neuroses, forensic psychiatry, and groups that present special problems, such as the alcoholic, the aged, and the so-called problem families "which baffle social workers and constitute a nuisance as well as a focus of infection for their environment."

The federation would be glad to send a copy of the booklet to any one interested in activities in the mental-health field. Write to Mr. H. Nieuwenhuize, Secretary General, National Federation for Mental Health, Prinsengracht 717, Amsterdam C. Postrekening, Holland.

A "Directory for Exceptional Children," listing schools, services, and other facilities, both public and private, throughout the United States, has been issued by Porter Sargent Publishers, of Boston. The facilities are listed both by state and by type — for the blind, the deaf, the mentally deficient, etc.

According to the introduction to the directory, it is now estimated that 12 per cent of all school-age children require special attention. Of these approximately 65,000 are blind or partially seeing, 500,000 are deaf or hard of hearing, 335,000 are crippled, 500,000 are delicate or of lowered vitality, 500,000 have speech defects, 675,000 are mentally retarded, 65,000 are epileptic, 675,000 are intellectually gifted, and 850,000 have behavior problems.

The directory should be of interest to parents, teachers, school administrators, pediatricians, psychiatrists, social workers, and all others who are concerned with helping exceptional children.

For further information about the directory, write to Porter Sargent, Publishers, 11 Beacon Street, Boston, Massachusetts.